MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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International Trade Center
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-and-

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AGENDA PAGE

P R O C E E D I N G S

[10:05 a.m.]

DR. CHERNEW: Hello, everybody, and welcome to our last meeting of this cycle. We're very excited for the topics we have today. This is a bit new for us, so please be patient. We are in person or, as Dana said, "MedPAC 3D," or in my case it's MedPAC with shoes. But we are thrilled to be here. We have a lot of important topics. We're going to jump right in.

So I'm going to turn it over to Nancy and Kim to talk about Part B drugs. Nancy, are you starting?

MS. RAY: I am. Thank you, Mike.

Good morning. The audience can download a PDF of the slides on the right-hand side of the screen.

An important driver of Medicare Part B drug spending is the price Medicare pays for drugs. Manufacturers set launch prices based on what they believe the U.S. health care market in part will bear and have set high prices for many new drugs whether or not there is evidence that it is comparatively more effective than existing standards of care. High prices and a lack of price competition among existing drugs is also a concern.

Today's session is a follow-up to three approaches we discussed at the October 2021 meeting that focus on Part B drugs and aim to address launch price and lack of evidence of certain first-in-class drugs, the lack of competition among Part B drugs with therapeutic alternatives, and financial incentives associated with the percentage add-on to Medicare Part B's drug payment rate.

We would like your feedback on these policy options. This material will be included in the June 2022 report. And while we are focusing on Part B drugs, some of the issues may be applicable to Part D drugs and to other technologies, including devices.

During this morning session, we will start with some background about trends in drug spending and pricing, and then we will move to the three approaches that Commissioners expressed general interest in pursuing during the October 2021 meeting. The first option would apply coverage with evidence development and set a cap on payment for select first-in-class drugs with limited evidence. The second option would apply reference pricing to drugs with similar health effects. And the third option models alternatives to the Part B drug add-on payment.

In 2020, Part B drug spending was nearly $41 billion, with spending increasing at nearly 10 percent per year between 2009 and 2019. Higher price is the largest driver of cost growth. Spending is highly concentrated in cancer, rheumatoid arthritis, and eye drugs. Twenty products accounted for 52 percent of the total spend.

Although spending is concentrated among high-priced drugs, Part B also covers low-cost products like corticosteroids and vitamin B-12 products that account for a large share of administrations.

The concerns about drug prices listed on this slide are not new. Estimates suggest that U.S. drug prices are roughly double the prices in OECD countries. Higher prices in the U.S. reflect higher launch price and more post-launch price growth.

According to some researchers, high launch prices are not always related to a product's comparative clinical benefit. In addition, researchers have found that the price growth of certain existing drugs does not reflect new evidence of the products' effectiveness.

And some products approved under FDA's expedited pathways are launching at high prices with limited evidence

about their clinical effectiveness. Aduhelm approved under the accelerated approval pathway is a recent example of this.

So these policy options that we will be discussing today are designed to address concerns about the overall price Medicare Part B pays for drugs and the lack of price competition among drugs with similar health effects and to improve financial incentives under the Part B drug payment system.

Potential outcomes of these policy objectives include generating savings for beneficiaries and taxpayers and improving the financial sustainability of the Medicare program.

Medicare has few tools to address a product's coverage or payment. statutory and regulatory language appear to require fee-for-service coverage of Part B drugs for their FDA labeled indications.

Medicare pays providers average sales price (ASP) plus 6 percent for most Part B drugs. Most single source products are assigned to their own billing codes. The one exception to this is listed on this slide. Separate billing codes may not always promote the strongest price

competition, with the manufacturer effectively determining Medicare's payment rate for the product. And Medicare's payment policies generally do not consider whether a new product results in better outcomes than its alternatives.

I will discuss with you the first two policy options that aim to affect manufacturers' pricing behavior for certain first-in-class products and for drugs with therapeutic alternatives. And then Kim will discuss modifying the add-on to Medicare's payment rate for most Part B drugs, to address concerns that the add-on might influence providers' prescribing patterns.

So under the first approach, Medicare would collect clinical evidence about the new drug through coverage with evidence development (CED) and cap a drug's payment using information about the new product's comparative clinical effectiveness and cost effectiveness.

This policy option would focus on first-in-class Part B drugs that the FDA approves based only on surrogate or intermediate clinical endpoints under its accelerated approval or other expedited pathways. We envision that Medicare would have discretion to use this combined approach for those drugs with limited and conflicting

clinical evidence.

A combined approach and applying coverage with evidence development and capping payment based on cost-effectiveness analysis has the potential to improve post-market evidence development and improve Part B drug payment.

Under this combined approach, Medicare would apply CED to generate clinical evidence on, for example, a new drug's risk and safety profile or impact on patients' functional status and quality of life. Under CED, Medicare links coverage of an item or service to collection of evidence in an approved clinical study or registry.

I'd like to mention that focusing CED on first-in-class drugs with limited clinical evidence is not intended to affect the program's ongoing application of CED for other items and services. As pointed out in your paper, there are roughly 20 ongoing CED efforts.

Under the second part of this approach, Medicare would cap a drug's payment rate based on an assessment of the comparative clinical and cost-effectiveness of the new product compared to the standard of care. Cost-effectiveness analysis compares the incremental cost in

dollars of one intervention with another in creating one unit of health outcome.

Pairing cost-effectiveness analysis with CED reflects the uncertainty of selected accelerated approval drugs on health outcomes when these products are launched.

A well-defined, transparent, and predictable approach would be key with implementing this combined approach. Note that there are currently opportunities for public comment when the agency proposes CED. Medicare would need to establish a process for identifying drugs for the combined approach, and there are technical complexities specific to implementing CED and cost-effectiveness analysis, some of which are listed on the slide. I'd be happy to discuss any of this more on question.

So now let's shift gears. We now turn to an option that could address concerns about pricing for drugs with therapeutic alternatives.

One driver of Part B spending growth is high launch prices and post-launch price growth among products with therapeutic alternatives.

Because Part B pays each single source product based on its own ASP, it does not promote price competition

among therapeutically similar products.

In 2017, the Commission recommended a consolidated billing code policy for biosimilars and originator biologics, which is a type of reference pricing that would pay these products the same average rate to spur price competition.

Building on that, reference pricing approaches could be considered more broadly for single source products with similar health effects as a way to promote competition and value.

So here's how a reference pricing policy might work. Each product in a reference group -- that is, a group of single source products with similar health effects -- would remain in its own billing code.

Medicare would set a payment rate for the reference group. This slide lists three examples of how payment could be set. The reference price could be based on the lowest ASP of a product in the reference group; this is often called the least costly alternative.

Another approach would be to calculate the reference price based on a volume-weighted approach; this is the method for determining the ASP of a branded drug and

its generics.

Alternatively, the reference price could be based on the minimum of the volume-weighted ASPs of all the products in the reference group or the ASP of the specific product furnished. The latter approach is currently used for a narrow group of inhalation drugs.

This slide lists some of the implementation issues associated with reference pricing. It will be key for CMS to establish a transparent and predictable process to identify groups of products with similar health effects, a process for medical exceptions, and a process for instances when the clinician and beneficiary opt for a more costly product not supported by medical necessity. Also important will be providing pricing information to beneficiaries and clinicians so they can make informed decisions, and it will also be important to address whether Medigap could cover cost sharing that is greater than the reference price.

So reflecting on these two policy options, it's important to recognize there would be several overarching complexities and challenges.

Implementing cost-effectiveness analysis and

reference pricing for select drugs are approaches that the Secretary would need statutory authority to implement. Additional resources for the agency to develop and implement these approaches might be warranted.

One challenge is that any coverage or payment decision that is perceived to affect patient access to a product or drug payment rates may result in patient, clinician, or manufacturer dissatisfaction. Examples are outlined in your paper.

There may be issues to consider related to the implications of Medicare policy on drug research and development, which are also outlined in your paper. I'd be happy to discuss any of this more on question.

So now let's pivot again with Kim discussing options to modify the ASP add-on.

MS. NEUMAN: So Nancy just discussed two options to address concerns about high drug prices and manufacturer pricing incentives. Next, I'll talk about options to improve incentives from the perspective of providers.

While clinical factors play a central role in prescribing decisions, financial considerations may also play a role in some circumstances. For Part B drugs,

Medicare generally pays providers the average sales price plus 6 percent. ASP is the manufacturer's average price net of price concessions with certain exceptions. The price that an individual provider pays to purchase a drug may differ from ASP for various reasons, including price variation across purchasers.

Concern exists that the 6 percent add-on to ASP may create incentives for providers to choose higher-priced drugs in situations where therapeutic alternatives exist. Several studies examining prescribing patterns for specific products found increased utilization of higher-priced products that may reflect the effect of the 6 percent add-on. In October, Commissioners expressed interest in exploring alternatives to the 6 percent add-on.

So we've developed three illustrative policy options building on past work in this area.

The first option would place a $175 limit on the 6 percent add-on. We chose $175 as an illustration. In 2019, about a quarter of Part B drugs had an average add-on payment exceeding $175, accounting for less than 7 percent of all drug administrations and nearly three-fifths of total add-on payments. A rationale for this approach is

that a percentage add-on is particularly inefficient for high-priced drugs. Also, a large add-on on top of an already expensive drug raises concerns from a beneficiary cost-sharing perspective. While this approach would address incentives for use of very high-priced drugs, it would not address incentives across less expensive products.

The second option takes a different approach. It would pay an add-on of 3 percent plus $21 per drug administered. We arrived at the $21 by reducing the percentage add-on from 6 percent to 3 percent and converting the revenue generated into a flat fee spread across all drug administrations. This option would reduce by half the difference in add-on payments for a high-cost versus low-cost product. An issue to consider with this option is whether the relatively large $21 fee for very inexpensive drugs is a concern. In 2019, about half of all Part B drug administrations had an add-on of less than $1, so $21 would be a large increase.

We modeled a third policy option combining Options 1 and 2 to address some of the issues raised by each option separately. Option 3 would pay the lesser of 6

percent or 3 percent plus $21 or $175. So what this would do is maintain the 6 percent add-on for drugs with an ASP less than $700, reduce the add-on to ASP plus 3 percent plus $21 for more expensive drugs and then cap the add-on at $175.

So to illustrate the effect of the various options, this next chart displays add-on payments for differently price drugs under current policy compared with the three options. The add-on payments in this table are pre-sequester.

Option 1, which places a $175 limit on the 6 percent add-on, focuses on high-priced products. We can see that under Option 1 the add-on is the same for a drug with an ASP of $3,000 or $15,000. In contrast, under current policy, the add-on is much larger for a $15,000 drug than a $3,000 drug.

Option 2, which would pay an add-on of 3 percent plus $21, has the most effect on incentives across low- and mid-priced drugs. As we compare the add-ons for drugs with an ASP of $5, $100, and $1,000, we can see that the difference in add-on payments across products in this price range is narrower under Option 2 than under current policy.

Also, as mentioned earlier, the add-on for a very inexpensive drug -- such as a $5 drug here -- would increase substantially.

Option 3, because it's combined Options 1 and 2, bridges the gap between these two options. It would have the most effect on incentives across mid- and high-priced products, as shown on the slide.

So to explore the effects of the policy options, we simulated their first-year effect on total Part B drug payments in 2019 assuming no prescribing changes.

To the extent that the policy spurs providers to substitute lower-cost drugs for higher cost-drugs, savings could be higher.

In terms of the effect on aggregate Part B spending, Options 1 and 3 generate savings -- about 1.9 percent and 2.6 percent in our simulation, respectively. In both options, payments decrease across specialties and provider types by varied amounts.

Under Option 2, there are no aggregate first-year savings, but the option redistributes payments across providers. So specialties and provider types that utilize very low-cost drugs will see payments increase, while other

specialties and provider types will see payment decreases.

So in thinking about the options to modify the 6 percent add-on, there are several issues to consider.

First, what is the effect on providers' ability to acquire drugs at the Medicare rate?

In the past, stakeholders have raised concerns about small purchasers' ability to acquire drugs if the add-on is changed. Data on providers' acquisition costs for drugs are limited, and it is unknown whether prices vary across purchasers for expensive drugs. But it is in manufacturers' interest to ensure that providers are able to acquire drugs at a price in line with the Medicare payment amount. And as we discuss in your paper, there is evidence of manufacturers' changing pricing patterns in response to past policies.

Second, what is the effect on incentives of the different options? Comparing the options, each would address the incentives to choose higher-priced drugs, but would focus on a different price range of products.

Another factor to consider is whether the options would create any countervailing incentives in terms of, for example, dosing frequency or volume, and I'd be happy to

discuss any of this on question.

So, in summary, we've discussed three policy approaches: The first, to address high prices and coverage for products with limited clinical evidence; the second, to spur price competition among drugs with therapeutic alternatives; and the third, to improve provider incentives under the ASP payment system.

Given the different focus of each of these approaches, there could benefits in packaging them together into a multi-prong approach.

As Nancy mentioned, this topic will be included in the June report, so our goal for today's discussion is to get your feedback on the issues and policy options discussed so we can incorporate them into the report.

We'll turn it back to Mike.

DR. CHERNEW: Great. Kim and Nancy, thank you very much.

There is a ton of material here, so before we jump in, let me just say for those listening at home, we're in many ways at the beginning of this discussion, sorting through a range of possible options. We are not at the stage yet we're actually recommending any of these

particular things. We hope to move towards that place. But I don't want the audience to believe or interpret that these policy options are the limited set of things that we are going to consider. We may consider more; we may consider less. That's what this discussion is, to take it simply for what it is, which is sort of an interim discussion on the way to sorting out what is a really very important issue, I think, for the Medicare program.

That being said, I know we have a queue now, so, Dana, I'm going to turn it over to you, even though we're in person, to manage the queue. Dana.

MS. KELLEY: Okay. I have Bruce first.

MR. PYENSON: Thank you. I've got, I think, three questions. One on Slide 9, you mention CEA, comparative effectiveness analysis. CEA has been branded with -- you know, here's what different -- an organization thinks is the official way to do CEA, and I'm wondering if you've associated -- if you're using the term broadly or narrowly. So the official approach to CEA includes QALYs and things like that, and there's many other approaches.

MS. RAY: Right, so I'm not -- I think the answer to your question is I'm using the term broadly. I'm not

endorsing any, you know, individual group's use of it right now. And I think this is -- if this was something for us to continue to look into, I mean, I think this is a methodology for Medicare to adapt that Medicare would have to propose how they were going to -- how the agency would use it, just as they tried to do back in the day when they tried to implement cost-effectiveness analysis in the coverage process, for example.

MR. PYENSON: Thank you. Another question. On Slide 12, you describe "own billing code." And, of course, every drug has its own NDC, so are you saying its own HCPCS code?

MS. RAY: Yes, yes. So under the reference pricing policy that we've put forward here, each drug would stay in its own HCPCS code. So let's say there's three drugs in the reference group. They would each be assigned to their own HCPCS, and then a reference price would be applied to all three.

MR. PYENSON: Isn't that sort of accomplished today? There's three drugs put into the same HCPCS and you let the ASP float on the average?

MS. RAY: So that would be more -- I think what

you're just describing would be the consolidated billing code approach in what's used right now for a brand drug and its generics. I think for the reasons outlined in the paper, we were thinking that keeping the products in their own code, you know, could be an easier -- could have easier implementation implications. However, I think that's something for Commissioners to discuss, keeping products in their own code and applying a reference price versus a consolidated billing code, which would put all the products in a single code and, you know, calculating the price accordingly.

MR. PYENSON: Thank you. Slide 16, you describe three different alternatives. Are there also other fees for administration that occur with Part B drugs?

MS. NEUMAN: Yes. So under the physician fee schedule, the provider will typically bill for the type of administration, whether it be an injection or infusion or subsequent hour. So depending on the type of product and where it is injected and so forth, there are different rates, yes.

MR. PYENSON: Do you know offhand sort of how big those are?

MS. NEUMAN: So it really varies. The simplest injection is going to be under $20, but a chemotherapy infusion is much higher than that. So there's a real range and so forth.

MS. RAY: You know, I was going to say -- I can't remember if it was our June '16, '17, or '19 report, I'm sorry, but we did compare the aggregate total payment for Part B drugs versus the total payment for the administration of those drugs, and there was quite a difference between the two. We can find that out and at least shoot that over to you by email.

MR. PYENSON: Good. Thank you.

MS. KELLEY: Okay. I have Lynn next.

MS. BARR: My questions are also on the same line. I'm curious as to why we're paying 6 percent. You know, how did this payment policy evolve? Are there inventory costs? Is there -- you know, I mean, what is the rationale if it isn't for the administration? And so by going from 6 to 3, is that a good thing or a bad thing. I don't know what it's paying for. Can you help me understand that?

MS. NEUMAN: So the 6 percent was established

when the payment system was changed from 95 percent of AWP to ASP plus 6 percent, and this has been a longstanding question about what is the purpose of the 6 percent, and there's no consensus.

One rationale is that prices vary across purchasers for some products, and so the 6 percent provides some cushion for that situation. There can be other reasons why a provider may purchase a drug for a price other than ASP, so it also can provide cushion for that situation.

Some have suggested that it also is covering certain administration costs, but as you guys have both discussed, there is a separate administration fee. And then, Nancy, are there any others that -- offhand? That would be the -- that would be sort of the, you know, top line rationale that has been given for the product.

DR. CHERNEW: I just want to jump in and make one related point. There's two separate issues. One is the amount of money and the other is the form with which the money is paid. So 6 percent is not just an amount of money. It also has an incentive effect discussed in the chapter. And I think if you look through the options,

there's some aspect about the amount of money, and then there's some aspect about changing the incentives that people have. And so that's what we're sort of playing with, so it will cover some of that. The inventory point which you made is the other one that actually would go with the price.

Correct me if I need to correct it?

MS. NEUMAN: [off microphone] – We're having a side conversation about other rationales for the 6 percent add-on, so we could fill in our description a little bit more. There's some other factors such as the lag in the ASP payment rates, so the ASP payment rates are lagged by two quarters, so that 6 percent could help with that. And then there's also prompt-pay discounts that are sometimes paid to wholesalers that are not always reflected in -- or passed on to purchasers, and so that can have an effect on the difference between ASP and what a provider pays.

MS. KELLEY: Okay. I have Pat next.

MS. WANG: Thanks. This also has to do with ASP. So 340B providers now are reimbursed ASP minus 22 percent, right? So this proposal about the add-on has nothing to do with 3 -- there's no -- there's nothing in here that would

recommend a change to the 340B reimbursement?

MS. NEUMAN: There is nothing directly focused on 340B in this approach. 340B providers are paid the 6 percent add-on, though, for pass-through drugs. So to the extent that you change the 6 percent add-on broadly, the policy would apply to that segment of 340B payments.

MS. WANG: Just roughly, proportionately, of Part B drugs that are being used, what proportion have the ASP add-on -- like how big a problem are we trying to address here with this proposal?

MS. NEUMAN: So roughly 20 percent of Part B drug spending goes through 340B.

MS. WANG: Okay

MS. NEUMAN: And then a certain chunk of that is going to be pass-through.

MS. WANG: Okay.

MS. NEUMAN: So it's a little bit less than 20 percent that is getting the ASP minus 22.5, so everything else would be getting the 6 percent.

MS. WANG: So this is pretty broad then. So just with the reapplication of the resumption -- with the resumption of the sequester, does that mean that the

proposal to do ASP plus 3 percent, that effectively it will be ASP plus whatever, 1-point-something percent?

MS. NEUMAN: The sequester applies to Part B drugs like other services, so it would reduce the add-on. As it kind of does the 6 percent add-on, it would do the same to whatever add-on you decided upon.

MS. WANG: Okay. Thank you.

MS. KELLEY: Amol?

DR. NAVATHE: Thank you. I have a few different questions here. One question is, in the write-up, I think, in talking about the internal reference pricing versus consolidated billing code, it seemed like there was a -- the way the write-up sort of laid it out is these are both the potential options. It seemed like in describing the advantages versus the disadvantages, that there were advantages described of the internal reference pricing, not so much the consolidated billing code. So I was curious, are there any advantages of the consolidated billing code that you would highlight given that -- I don't think I saw them in the write-up.

MS. NEUMAN: So we highlighted the reference pricing and the separate billing codes as being more

flexible for CMS when products might have different dosings that are being considered and so forth. And so that is an advantage of it for those kinds of products.

To the extent that you would have products where it was very a simple one-to-one, sort of like brand-generic but not quite that, then combined billing code is really slick and easy. It's when you get more complicated comparisons where keeping them separate really gives you advantages.

DR. NAVATHE: I see. But just so I understand, even in the case of the slick and easy, you still would compromise to some extent the ability for researchers or CMS or MedPAC to be able to actually track the use of those, the differences between those drugs?

MS. RAY: Right. I mean, that certainly is an advantage of the reference pricing and keeping each product in its own HCPCS, is that administrative claims could -- you could continue to conduct pharmaco-epidemiology type studies using the claims data.

DR. NAVATHE: Great. Okay. Thank you.

I have a second -- I have four questions. So my second question is: I believe the mailing material had

made reference to prior to the Medicare Modernization Act that there was some authorities that the Secretary had around using some of these policies, specifically, I think, around the reference pricing. And so, one, I wanted to make sure I understood that correctly. And, secondly -- because it sounds like maybe I didn't. And then, secondly, were there any particular guidelines around whatever you will clarify for me kind of what the Secretary did have authority to do, how the drugs were actually related to one another, and how those policies were made, because it seems like in deciding internal reference pricing or consolidated billing codes or least costly alternative, any of these policies, the devil is in the details of what gets lumped together and what doesn't. So I was curious if there was any precedent in terms of guidelines, for example, that have been published or anything that we could look at in the historical perspective.

MS. RAY: Yeah, so CMS in one instance implemented least costly alternative -- I think it was beginning roughly in the mid-'90s through 2010 -- on a group of prostate cancer drugs. And what happened -- and they implemented the least costly alternative policy, which

was essentially reference pricing, the products stayed in their own HCPCS, using their reasonable and necessary authority out of 1862(a). So there wasn't, so to speak, any explicit statutory authority.

And so that was taken to court, and after a series of court rulings that held that the agency had to pay according to the MMA, which said that each drug and its own billing code gets paid its own ASP, and that's why they had to discontinue the least costly alternative policy.

So I think the lesson learned there, at least from my perspective, is that the agency would need statutory authority, I think, to proceed with this type of policy for Part B drugs moving forward.

DR. NAVATHE: I see. Okay. Thank you. That's very helpful.

Sorry, two more questions, one very weedsy and then one very not weedsy. On page 65 of the mailing materials, there was a description about the manufacturer's response to implementation of the sequester, and specifically this notion of changing their pricing patterns to mitigate the effect of the sequester on providers' margins. And in that paragraph, and I think in the

analysis that accompanies that paragraph or supports that paragraph, there was a description of how the -- and the table, how the percentiles basically were affected of the percent of ASP. And what I was curious about there is I think I understood what was happening in terms of the price -- the way that the ASP percentiles were changing, but I was curious -- I don't think I understood exactly what the manufacturer's response was and how that was actually -- what was the underlying mechanism basically for the response and what we saw in terms of what shows up in Table 6?

MS. NEUMAN: So the data that we had for that analysis gave us sort of the percentile distribution of prices for products, and we were able to see that when the sequester hit, suddenly the 75th percentile price dropped about as much as the same amount of the sequester, and then it sat there going forward quarter after quarter. So it looked like a very lockstep drop.

Now, what you see in the data is only that percentile price. We don't see, you know -- we don't see what's happening at the channel level or the purchaser level and that kind of thing. And so one hypothesis is

that they narrowed their price distribution across purchasers. There could be other ways to adjust with other channels and things of that sort. So we can't say for certain the mechanics that arrived at that, but we see in lockstep that sort of drop.

DR. NAVATHE: Okay. Thank you.

All right. My non-weedsy question. When we're considering the different options, I think on Slide 16, for example, it's noted, you know, there's a differential effect depending on the distribution kind of where a drug is and the price distribution as well as between Option 2 and the other options whether there's a kind of overall budgetary impact, if you will, in applying this policy without taking into account any sort of response by manufacturers or providers.

So I was curious, at a high level, as we are thinking through these options or even coming up with these options, is there -- I guess to some extent what are the goals? Have we outlined what we're seeking as an objective? I know in general from the background and from this body of work that we're trying to address high price growth or high prices for Part B drugs and to some extent

Part D drugs. But what I'm trying to understand basically is, you know, kind of what is the litmus test for evaluating these policies. Is the goal, in fact -- should we have the goal, in fact, or is the goal, in fact, to try to address the highest-priced part of the distribution? Is the goal, in fact, to say this is a simulated -- this is a simulated policy option, but we're trying to solve for roughly budget neutrality because that's a conceptual exercise we're trying to do as part of the subjective -- to understand these options and evaluate them I thought it helped -- it would be helpful to actually understand if we have an explicit objective in terms of the distributional and budgetary effects.

DR. CHERNEW: Maybe you should go, but I'm happy to say something about this if you're uncomfortable saying something about this. So you guys decide.

[Laughter.]

DR. CHERNEW: All right. Let me take a stab at this, and then you guys can confer. I think the acknowledgment is when you -- because of the way that prescription drug markets work, the innovation is very important, and we give the innovators patents, which I

think we would agree, by and large, is an important thing to support innovation of good drugs that add a lot of value. I don't want to have a huge debate about broad drug policy innovation, though we could.

That being said, if you give that type of power and throw it into an insured market, particularly where Medicare is paying, you lose any type of discipline on pricing beyond what you would think would normally happen in a patented-type market. And so there's a number of areas of inefficiency that go on where we see things that I think one would argue were clear problems.

One would be the incentives for using the high-priced drugs and the lower-priced drugs would be -- acceptable, or good, or I don't know what the right word is, but you understand.

Two would be the drugs being in a separate code that will just have no pricing pressure. There's no competition between like things, so there's no market working even when there's a new drug that might not be marginally better, the pricing process may generate a price that's more than one would think would be the efficient price, even accepting that we need to promote innovation in

this space.

And the third has to do with the problems associated with the evidence when new drugs that are -- many of the cancer drugs are very important. What happens in those cases where we haven't fully -- I don't know what the right word is -- been able to vet and get all the information on the drugs and what happens to the spread of their use and the price that we're being charged.

So I think the broad purpose of this work is to try and find a balance between what I think the patent system is designed to do, which is promote innovation of high-value drugs -- and if you look at the COVID vaccine and some of the cancer drugs, I think there's a potential for a lot of value there -- with sort of the fiscal concerns associated with ways that we pay that move away from the broad MedPAC view of we're trying to pay efficiently for the care that we need. What differentiates this from, say, when we do hospital or physician payment is this very complicated interplay with innovation and how that plays out.

And so at the margin, I think we're trying to find ways to change the payment models that will maintain

the core principle of rewarding innovation and promoting access to high-value drugs while still meeting potential fiscal challenges that arise because we're dumping all these high-value drugs into this insured, very low downward pressure system of paying for them. And so that's -- I don't know.

I've spoken long enough that maybe Nancy or Kim want to add, or, Jim, if you want to add, but that's my loose answer to what we're trying to do.

DR. NAVATHE: Okay, can I just --

DR. CHERNEW: Yes.

DR. NAVATHE: Okay. Actually, let me shift it to Round 2.

MS. KELLEY: Brian, did you have something you wanted to say about a question Amol asked?

DR. DeBUSK: Yes. On Amol's point about the consolidated billing codes, even if the HCPCS code has been consolidated, the NDC is still on the claim, I believe. Or does it truly destroy the data?

MS. RAY: I think that it -- my understanding is right now you may not be able to track certain products as well as you can with the unique HCPCS code.

DR. DeBUSK: Okay. So if a bill -- a 1500 form, put the HCPCS code on it, there isn't a place there for the NDC? Or is it just not used in practice? Is it a technology issue or is it a work flow practice issue?

MS. RAY: You know, honestly, I would have to get back to you on that.

DR. DeBUSK: Okay.

MS. RAY: How well the NDC is reported on the carrier claims versus the hospital outpatient and the DME claims.

DR. DeBUSK: Thank you.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: So perhaps these are questions that were addressed in the chapter and I just missed them. To me this is just an issue of fairness. We don't want to penalize physicians financially because they are prescribing drugs that bring in little revenue on their part.

I guess my question is: Do we know that physicians are overprescribing certain drugs because of the amount of money they make by prescribing those? Is that a fact we know? And I guess -- I would think the only way to

know it is to compare them with the kind of prescriptions done under MA. Does the same patient with the same issue tend to get just as effective but lower-priced drugs when they're in MA but that doesn't work when they're -- so I'm just trying to figure out whether this is just a fairness issue or whether this is really an issue of physicians who are blatantly overprescribing because they bring in a lot more money.

MS. NEUMAN: So I think there's first the idea of like a theoretical financial incentive from a percentage add-on that is sort of a concern that's driven this body of work. In terms of the extent to which that incentive is being acted on is another question, which is what you're raising, and I think it is very difficult to disentangle differences in utilization patterns in the research and say this amount is because of differences in patients, this amount is because of changes in practice patterns, and this amount is because of financial incentives.

What we see in the literature is that when people have tried to look at particular products and look at changes in payment or MA versus fee-for-service, we do see some higher use of high-priced drugs, and so there is the

potential that that is being driven by the 6 percent add-on.

That said, to be able to conclude that that is actually what is happening is a difficult thing.

MS. KELLEY: I have one more from Larry.

DR. CASALINO: Just in terms of Marge's comment, I think everybody knows this, but there are some specialties in which a good part of their income comes from the injection of Part B drugs, for example, oncology and ophthalmology. And, actually, probably one potential unintended consequence of cutting that income would be more consolidation of oncologists and ophthalmologists with hospitals than there is. There isn't much with ophthalmology, but there's a lot with oncology.

But my Round 1 question is this: Assuming that one aim potentially of going through this -- I'm talking now about the third policy option, ASP plus 6 percent for injections. Assuming that one aim is to try to save Medicare money, the percentage savings are -- when I got to that part, they were -- and thank you for putting them in -- they were relatively small. I mean 2 percent of a lot of money is still a lot of money. But, on the other hand,

going through the political uproar that would emerge if any of these options, 1, 2, or 3, were attempted, one would wonder if the 2 percent was worth it.

My question is -- and, by the way, atypically, no one has said this yet, but it's a magnificent chapter. There's so much information in it. People can't really get that from the slides. But it was like a tremendous primer on the whole area. It's also like reading "War and Peace," which is a novel I love --

[Laughter.]

DR. CASALINO: -- which I've read multiple times, but this I may not read multiple times. But it was of the same level of quality.

But my question is: Have you done any kind of jiggering around with -- if you changed the 175 to 150 or 3 percent to 2 percent or 6 percent to -- in other words, changes that for any individual provider would be pretty small, but how much more savings would that make for Medicare potentially could get us above 3 percent, for example.

MS. NEUMAN: So we don't have a lot of sensitivity analysis right now around these parameters, but

that kind of thing is definitely possible.

DR. CHERNEW: Yeah, so, Larry, let me just say two things. Once we get a sense after this discussion of where to go further as we move on in this work, we can do more sensitivity analysis. This is more to show the principle of what could be done. There's nothing magic about the specific numbers.

The second thing I'll say in response to your question that may not have been clear, any numbers that are mentioned don't assume a particular behavioral response. I think that's right. So we're not assuming that when we change the 6 percent to less and the incentive change, despite -- there's good material in the chapter that shows that physicians, the medical community in general responds to the incentives. But associated savings aren't -- if I follow correctly, Nancy and Kim, they haven't modeled those types of savings. So they've basically said given the existing patterns, this is what would happen, this is what the savings would be. But, in fact, you might expect that's going to be leveraged by changes, for example, if you made biosimilars in the same code, then people shifted to biosimilars. There's a lot of other follow-on things

that haven't been captured. Is that basically right?

Let the record show Kim's nodding yes.

Now I think we have about half an hour and --

MS. KELLEY: Lynn had one more question.

DR. CHERNEW: Okay. We have Round 2, and we have half an hour, and so there's a lot --

MS. BARR: Sorry I'm still stuck in Round 1. I apologize. I just have a couple more questions.

I wondered what the rationale was for the $21. I'm still trying to figure out what we're trying to pay for here. And my other -- I'll just ask both questions. If what we're trying to do, the 6 percent, is to adjust because we don't know the price, why don't we just pay the providers the price? I don't understand the -- like, I'm still struggling with why we're doing this? Is that Round 2?

DR. CHERNEW: That's going to be a Round 2 question.

MS. BARR: Okay. But the rationale for the $21, I'm still -- I'm trying to understand why 21.

MS. NEUMAN: Sure. So one of the ways people have talked about changing the 6 percent add-on is to move

it all into a flat fee. And so what we did is we just cut the 6 percent to 3, and then we said whatever money was generated by that will create a flat fee that's budget neutral. You wouldn't have to do it that way, but because, as Mike said, this is an illustration, we just, you know, showed you what it would look like.

DR. CHERNEW: The goal is -- the 6 percent provides an incentive that a flat fee doesn't. So it's not about the amount of money necessarily. But, again, we should probably jump to Round 2. I know a lot of people have a lot of things that they want to say about a lot of material, and I think Stacie is first because she got in last night.

[Laughter.]

DR. CHERNEW: So we'll go Stacie, and then Dana will run the queue.

DR. DUSETZINA: Great, thanks. Kim and Nancy, this is an extraordinary chapter. I really appreciate the amount of work that went into it. I want to make points about each of your questions here.

I think to start out, too, the overarching framing, one of the things I noticed is, you know, we start

out talking about innovation awards and affordability, and I think that some of the questions, maybe Amol's question might have pointed out, we could also think about framing around how do we pay for drugs with uncertain clinical benefit, how do we increase price competition in Part B, and how do we remove incentives that basically create a demand for high-priced drugs or high-priced drug use? So I think that we could maybe think about modifying that kind of setup a little bit to emphasize those goals, maybe a little bit more than the innovation access type of trade-off.

For the question around the first-in-class drugs and drugs approved through accelerated approval, I think I am incredibly supportive of the idea of doing some sort of price negotiation when it comes to those drugs. The one thing that I would quibble with is that I don't think we need to tie that to coverage with evidence development. I think we should leave it on the table that those drugs are by definition being approved with uncertain evidence, and that we should have the opportunity to negotiate in those cases, as the evidence that is being developed to show that they have clinical benefit is the responsibility of the

drug sponsors and a requirement of FDA. So I think that we should maybe broaden our scope not just with the CED requirement.

I, of course, we'd have to lay out some very clear guidance on what would qualify, and we would want to think about this as a cap on the prices rather than trying to reprice everything based on some sort of value threshold.

For the reference pricing piece, I love this. I think it's so important. And I am a really big fan of the idea of the separate codes, partly as I was trained as a pharmaco-epidemiologist and have a lot of friends who do drug safety work and use those codes regularly, so I like the idea of keeping them separate. And I like the volume-weighted average sales price across products because it kind of implicitly acknowledges that there may be some patients where some drugs are actually preferred for them. And I think that by doing a volume weighting, you create more of a financial incentive to use low-cost drugs most of the time without needing to have separate codes to pay more when you need an exception. So I think that that might also be something to emphasize.

I agree with the least costly alternative is maybe less of -- like something that I think we should pursue, but partly because in the chapter you mentioned that there was a legal challenge around that. I wasn't sure if there was like an option for -- like if that has evolved in a way that we think would make it so reasonable to do.

MS. RAY: So, again, when the agency was applying least costly alternative back in the day, beginning in the mid-'90s, they were doing it under their authority to only cover services that are reasonable and necessary, the 1862(a), I believe.

DR. DUSETZINA: Okay.

MS. RAY: And so that interpretation of the statute, what the court basically said is, look, there's more specific language that says you have to pay according to ASP now.

And so moving forward, it seems like to us that the agency would need statutory authority to do reference pricing, and then, you know, depending upon if the statute was specific or not, you know, how the pricing method would go could either be in the statute or that that could be

given discretion to the Secretary.

DR. DUSETZINA: Okay, great. One other thing that I think might be a nice opportunity in the chapter, you do such a great job showing the differences in the pricing of the biosimilars and the originator products, and I kind of wondered if -- you know, you mentioned generics that have been available and how that has induced price competition when they go into the same code. But I kind of wondered if now that we have the biosimilar pathway, has that basically made these traditional generics much more unlikely to happen. So I wondered if there's a way to further motivate why we need to do this now because we have these drugs coming out with these separate billing codes that have really made us, you know, restricted in how much price competition we could have.

And then on the last point around the ASP add-on payment, I really like Options 1 and 3. I think we definitely want to mention the administrative fee in the chapter because it does at least acknowledge there's this other source of revenue, so we won't necessarily need to worry as much about those lower-cost drugs because there are payments that are happening for those as well. And I

think that the example of paying a percentage add-on for something as expensive like CAR-T is a really good example of why we need at least a cap on the maximum amount.

But outstanding work, very supportive of these options.

MS. KELLEY: Lynn.

MS. BARR: Thank you. So I am very much in favor of reference pricing and your recommendations there. I think that is really, really important. And like I say, in terms of modifying that, I just want to really get a better understanding of what it is we're paying for with this 6 percent so that we don't, you know, cause harm to people and ensure that we're very explicit about how we would be replacing that. I'm definitely in favor of the add-on fee, a flat fee as opposed to the sliding scale. I don't think it was created in a time where we had the kind of drug prices we have today, and it seems very inappropriate as a payment methodology.

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Yes, thank you. I want to support a lot of the things that Stacie said about what a great piece of work this is and her modifications to the

first option, and I also support reference pricing and the third, like Option 1 and Option 3 better than -- Option 2 I don't care for.

But the point I want to make is that -- and actually in answer to Lynn's thing about 6 percent, is that I'm really glad that you did the analysis of what happened during the sequester as far as prices charged to physicians, because this issue about physicians in smaller practices perhaps losing money if we trim the markup under the ASP plus 6 I don't think is a realistic problem, because the expensive drugs are drugs, you know, where the manufacturing cost tends to be a very small percentage of the price. And, you know, it just seems to be a no-brainer that if some physicians cannot afford to administer drugs, the prices won't come down. And so this is my answer to Lynn's issue, is that, you know, there's nothing sacred about the prices charged. You know, they're part of a price discrimination, profit maximizing strategy, and, you know, they will adjust to prevent a situation where physicians cannot have the fully panoply of options to treat a disease.

MS. KELLEY: Brian.

DR. DeBUSK: First of all, I'd like to thank you both for a really great chapter, and I really appreciated the fact that you gave us three different options that were really trying to tease out different aspects of the problem. So it was really interesting to see that.

First of all, coverage with evidence development, I think there's real merit in what you're doing. I think in the chapter you did a really good job of outlining the issues, though. You know, what do you do if the evidence doesn't turn out? Do you remove approval of the drug, things like that? But I think there's a lot of merit in working in this area, and I hope that you develop all of that out, because I think we're going to have more shocks to the system. You know, these really high-price launched drugs, I think if nothing else, this is preparation for the future because I think the future is going to be, you know, Aduhelm all the time every year. Sorry to be -- but I do, I think you're laying really good groundwork there.

Now, the second area, this internal reference price, clearly that's the best opportunity to spur price competition. I'm going to try to build and maintain the argument, though, that, when possible, we should

consolidate into the HCPCS codes. And here's my thought: You know, Medicare serves as a leader in defining the structure of payment and defining the processes, the underlying processes for payments. They may not necessarily use the rate that we establish, but they do adopt the structure typically. And one of my concerns -- and maybe this is a Round 2 question, but, you know, if we, for example, left all the HCPCS, the J-Codes in place, and we just said, okay, now we're going to superimpose all this new pricing onto those codes, you know, what would keep commercial payers or, again, non-Medicare payers from just simply saying, well, we don't choose that option, what we would do is we're going to continue using an MASP markup failure. And I think -- and maybe this sounds a little cynical, but, you know, if you do consolidate the HCPCS code, which I realize risks destroying some data, but, again, you can recover that data if on, say, the 1500 form you entered the NDC, if you were willing to collapse it into a specific HCPCS code, you would -- or at least in theory you would force people to adopt that new mind-set. It almost becomes a default all-payer strategy.

And so my question is: If we didn't do the

consolidation and all those codes were still out there and we were just superimposing this new NDC blended -- or this new HCPCS blended price, weighted average price, my concern is that payers other than Medicare might undo it.

Then that brings me to the third option or the third discussion item which is the ASP restructuring, which I very much support. I think it's a great -- you know, to me this option really addresses the underlying motives and the incentives for physicians to make good choices on drugs or cost-appropriate choices. But I do want to raise that other issue again, which is, you know, what if we do come up with a 21 plus 3 percent, you know, some clever, more aligned incentive, my concern is there's really no requirement that commercial or other payers adopt that payment structure as well, so you could find yourself with an oncologist weighing a $10,000 drug versus a $1,000 drug, and we may have solved the problem through restructuring the ASP markup on our side. But if the problem still exists with all the commercial payers, are we really going to drive prescribing behaviors?

So, again, I hope we don't underestimate Medicare's role in really setting the pace and setting the

payment structure and that we still play. Thank you.

MS. KELLEY: Bruce.

MR. PYENSON: Thank you. As others have said, this is a really terrific chapter. I've got several suggestions, and some of them are perhaps a bit aggressive, and I hope they'll be considered as options as this work progresses.

The first is on accelerated approval drugs, and if we think about what accelerated approval means, it means allowing a drug to come to market without an additional Phase III trial. At least I think that's what it means, and so something gets accelerated, the manufacturer has the benefit of avoiding the expensive of additional trials, which often come with a risk. You know, a high portion of Phase III drugs never make it to market. The results aren't positive, it wouldn't get FDA approval, or it doesn't get FDA approval.

So if that's the construct that what acceleration means, I'd suggest that as part of coverage with evidence development, the manufacturer be required to post a bond that, if particular endpoints are not met, they have to refund the entire spending, including the administrative

costs, because, after all, there's a probability that they wouldn't have succeeded, they wouldn't have had any revenue, and they would have had extra expenses. So a bond like that could be purchased from an insurer, and that would be the downside, which currently doesn't exist at all for accelerated approval.

So I think that's a concept that ought not to be opposed by the manufacturers since it would balance the upside and downside that they currently would have with an additional Phase III trial.

On a different topic, Paul used the term "price discrimination" with ASP, and as the paper points out, the actual price that a particular provider, a physician, pays varies. They don't pay ASP. Some pay more, some pay less. I think we could avoid a lot of the issue around the add-on if we simply said this is a class of trade and it's discriminatory to charge different providers different amounts. I think there's precedent for that in other businesses, or at least there used to be. I'm not sure if now price discrimination is deemed to be valid according to economists or things like that. But if we -- the argument in the Part D space for having PBMs negotiate is that

they'll negotiate a better price from the manufacturers. It's hard for me to apply that argument to medical benefit drugs, right? That somehow there is -- because sellers vary the price, that somehow that helps create a competitive market.

So I think part of a solution is to just say all buyers for Medicare or just in general have to pay the same price for a particular Part B drug, and that would take away the concerns that Paul also was addressing on the variability of purchase price.

On the coverage with -- sorry, on the cost-effectiveness analysis, there are debates on what's the right way to do that, and whether QALYs are valid or not or whether we should have a broader social impact or societal impact taken into account, and you get different answers. So I'd suggest we be careful in how we write that. I'm all for ways to not pay so much for the drugs, and I think -- but CEA has taken on a brand name in some ways, and I want to be careful about that.

A couple of points Brian made I think are important. The markups that commercial is paying on these drugs dwarf the 6 percent that we're talking about and --

for physicians and dwarfed by an even greater amount for hospital outpatient. So I think that's a cautionary note. I'm all for the third option, which would save Medicare the most money, but I think the broader issue of what's going on on the commercial side is -- has to be recognized in how much effect we may or may not have on either physician income or physician decisionmaking.

And, finally, on HCPCS versus NDC, I think a recommendation might be that we require NDC coding. The current Medicare files for DME, for carrier, and for hospital outpatient all have fields for NDC codes. It's not clear how well populated they are. I think, you know, whichever way we go, that field has got to get populated, and one of the reasons is that, you know, NDC defines the package size, HCPCS doesn't. So you get a wealth more information for analytics. So while we're dealing with Part B issues, let's add to our list.

Thank you.

MS. KELLEY: I think there were a few people who wanted to respond to Bruce. Stacie?

DR. DUSETZINA: So I think the broad idea is intriguing, but I guess the two gut reactions I have are

that paying less the whole time rather than having this refund at the end has two benefits. One is that, you know, having to pay back the bond at the end doesn't give any incentive to actually finish those studies, and we know that's the current problem with accelerated approval. So I think paying less until you finish the study means you have more incentive to actually get to that clinical endpoint we care about, and it also avoids beneficiaries overpaying if they're paying their co-insurance during the time in that window. So I think that would be the only reason I'd say pay less up front seems better for beneficiaries and incentives to finish.

MR. PYENSON: I'd agree with both the bond and paying less. I mean, it's accelerated --

DR. DUSETZINA: I didn't realize it was an "and."

[Laughter.]

MR. PYENSON: Yeah.

DR. CHERNEW: I want to make sure we're aware that we have five minutes, four people. So if we could move -- if it's okay, if we could move on, I think the person who's next is Betty, if I have this right.

DR. RAMBUR: I can be very brief. I just wanted

to share my appreciation for this chapter. I thought it was actually a brilliant primer. And I just wanted to comment a little bit about the goals that are important to me and that I think this addresses.

One, it balances the need for innovation with the need for much stronger price competition. Caution about perverse incentives is actually really important, and Marge said something about, you know, prescribing. I don't -- my experience is that prescribers are not nefariously choosing the most expensive drug. It's just that what's permitted is promoted, and there is a lot of pressure to do that in many kinds of ways. So I think it's really important that that's addressed.

I appreciated recognizing the issues of access and beneficiaries' cost sharing as being an important issue. I'm still pondering the bond issue, and I agree, less along the way is good. But I just wanted to comment on cost-effectiveness analysis. That has become sort of a dirty word in many ways, and yet I think it's actually very important, however we would operationally define it or brand it, because I think beneficiaries and taxpayers would expect that. They would expect that it's cost-effective.

In terms of the options, I strongly prefer 3 over the others. I thought 1 was okay but not 2.

Thank you again.

MS. KELLEY: Jaewon.

DR. RYU: Yeah, many of the same comments that have already been made. I'll just add a comment on the add-on payment. I like Option 3 as well. I like the idea of caps. But I think there's a real incentive dynamic to this and creating perverse incentives or right incentives. I think the lower -- the ASP less than 700 category in that option, it just feels like there's a way to blend the options a little bit. And so whether for those lower-cost drugs going to the 3 percent plus 21, I think that creates a little more incentive for providers to be choosing those drugs, because I think the way that -- actually maybe you could shift to Slide 17, I think it was. I think the way that it's currently structured, it just seems like a very low add-on payment. And if it really is -- you know, the concept is that there's a buffer that you're creating for purchase prices being different, that seems like a level where a lot of people would be on the wrong side of that buffer. So I would strengthen the incentives there.

MS. KELLEY: Amol.

DR. NAVATHE: Thank you. I, too, will try to be fairly punchy and brief here.

So first off, I definitely want to echo the comments about just how fantastic this work is, and I think the way that it's laid out is really wonderful and very much a primer on this area.

Four comments. The first thing is I think kind of building upon my Round 1 question around the goal here, I think this is obviously highly multifaceted, and I think there's a number of different pieces that we're trying to solve for. We're certainly trying to solve for the innovation piece. We're trying to solve also, although we do a lot of the modeling, we're trying to -- we are trying to in part address some of the provider incentives because in some sense that's what we're fundamentally trying to alter here to get at a more cost-efficient program. We're trying to address some of the manufacturers' incentives around the pricing. So there's a lot of moving parts that we can't possibly model every piece of this, but I think if we can structure this a little bit more proactively in terms of a framework around how we expect these pieces

might as a portfolio approach, as we have started to do here, I think it might actually be a little bit more cohesive to understand, I think, the depth of thought and rationale that is going into this, that to some extent could be elevated by providing something more akin to a framework or a table of some sort to frame how these different pieces may end up fitting together as opposed to policy decisions that are being made in a silo for targeting one piece versus the next piece, which is, I think, maybe to some extent how this could be interpreted, or misinterpreted.

Second point, I think I also just wanted to in the public session voice my support for the approaches around that Stacie was kind of articulating and that have been in the chapter here around comparative clinical effectiveness and cost-effectiveness at a broad level, understanding that there's a lot of devils in the details there of actually connecting them to policy in a meaningful way, but I think it's worth taking on that effort, if you will.

Third point, so I wanted to articulate support for the reference pricing approach and particularly the

volume-adjusted or volume-weighted approach to those prices. I think it actually has a nice precedent to follow in other parts of the Medicare program, you know, in spirit. The way that DRGs, for example, were initially started was in this context of a yardstick competition from an economics perspective. This volume-weighted approach would actually sync up very nicely with that, and I think the more cohesion we create across the Medicare program to some extent, all the better.

And, lastly, I wanted to echo other folks who have said less support for Option 2 amongst the options presented, more support for Options 1 or 3. I would like to see, again, in the context of the framework, some framing around what we're really trying to achieve out of the option, and to some extent, my reading of it is we're most trying to address the top part of the distribution, the pricing decision. In that sense Option 1 might be a little bit simpler to get there just because Option 3 is a longer, more complex policy option.

Thank you.

MS. KELLEY: David.

DR. GRABOWSKI: Great, thanks. I'll also be

brief. Great work. I'm really excited we're pursuing this.

Stacie, I thought you teed this up really well. I'm on board as well for price negotiation. I really liked your point about CED and is that necessary, and so I think yes on price negotiation. I'm not certain coverage with evidence development is the way to go there.

I'm also very supportive of the reference pricing option. In terms of the ASP options, I also like number 3. In spite of the complexity that Amol just laid out, I think that gives us the most kind of control over growth there.

My final comment was just I was really struck -- and I knew this before, but if I did my math right, 12 of those highest spending drugs of the top 20 were cancer. I totaled them up to $13 billion. It really suggests there's a lot of work that could be done in that particular area. So I think that might kind of fit well with some of our other work on value-based payment and alternative payment models.

Thanks.

MS. KELLEY: Paul, did you have something you wanted to end with?

DR. PAUL GINSBURG: Yes.

DR. CHERNEW: Larry?

MS. KELLEY: I'm sorry. I do have you on my list here, Larry. Go right ahead.

DR. CHERNEW: I think the way we're going to do it, Larry, I think you have what was the original last Round 2 question. Then Paul wanted to say something after. So, Larry, you go, then Paul.

DR. CASALINO: This will just take a minute. I also like Option 3, though I'd be okay with Option 1 for the reasons that Amol mentioned. And reference pricing, however we do it, consolidating the codes or not, I also like. I think we're in good shape with both of those.

You know, in terms of the accelerated approval drugs, the first area that the paper discusses, I think Stacie's right to -- she said it in a very understated way, but I think she's right to point out that there would be implementation problems with CED and cost-effectiveness analysis that probably most or all of us think in concept that these would be good things to do, but in practice might be very difficult. But I actually thought that most of the Round 2 discussion would be about this issue, about

the first area, the accelerated approval drugs, because there's a lot of money there, and it's the toughest one to tackle. I really think we could spend an hour and a half easily trying to get at that, because maybe, Stacie, you had a solution, but if so, I didn't understand it. Again, you were very understated, Stacie.

So just as more of a process suggestion, I think that area needs a lot more attention from us. The suggestions were great, but, you know, because of the implementation hurdles, it would be great to hear more from other Commissioners about that.

DR. CHERNEW: And just to emphasize, as I said at the beginning, we are sort of moving through this journey, so this meeting that we're about to end has actually been very useful in helping us develop where we're going, and I think we will continue to develop them over time. This was not meant to be the end and we're going to vote next month. This is going to be -- this is April, so we have a whole other cycle to address this, which will surely be an hour and a half and then some.

Paul, do you want to finish up?

DR. PAUL GINSBURG: Sure. I just wanted to say

that I really disagree with Bruce's comment about price discrimination, and here's why. To me, in the prescription drug area, price discrimination is a tool for competition, and it's really a way that -- the ability of manufacturers to price discriminate gives the rest of the market an opportunity to actually employ competitive forces. And given that our political culture is very comfortable with competition -- at least that's what it says it is -- and even lowering prices through competition, I'm not so sure about regulation. I wouldn't want to constrain the limited options we do have to use competition more effectively.

You know, just one example, you know, the ability and the facts that many expensive drugs are -- the prices are extreme -- much, much lower in low-income countries, that's a good thing for the world, and it actually makes innovation more viable, because it expands the revenue from an innovative drug.

I also want to make a point about, you know, as far as the ASP plus 6, what are the commercial insurers going to do? I don't think it's as bleak as it looks because some commercial insurers actually have innovated in the direction that we're talking about. For example, for

drugs for macular degeneration, United Healthcare has sharply raised the payments, the margin it pays for the use of the much lower-cost drug Avastin. So in a sense, in relationships with physicians, public commercial insurers have more clout than they do in, say, dealing with manufacturers except through PBMs.

Thanks.

DR. CHERNEW: So we are a little over. We're still going to take a five-minute break. It actually now looks like it will be a four-minute break. But if we could just very quickly take a break, we will be back. We are going to start this with our discussion of -- continuing our drug theme, we're going to start the discussion of rebates at roughly 11:35-ish. Is that what we're going to do, Dana?

MS. KELLEY: That sounds good. Don't log out. Just stay logged into the meeting.

[Recess.]

MS. KELLEY: We are live.

DR. SCHMIDT: Good morning. In this session, Shinobu and I will describe initial steps we've taken to evaluate drug pricing data for Medicare Part D that the

Congress recently made available to the Commission. This follows our presentation from last October when we laid out our work plan for these data and got your feedback. Without these data, we've been able to track changes in the use of prescription drugs and gross Part D spending but unable to examine program trends and patterns of behavior related to plans' benefit spending net of rebates and discounts.

Before we get started, we'd like to thank our colleagues, Tara Hayes and Eric Rollins. And as a reminder to the audience, you can download a PDF version of these slides in the handouts section of the control panel at the righthand side of your screen.

The Consolidated Appropriations Act for 2021 included a provision that grants MedPAC and MACPAC access to two categories of proprietary pricing data, one related to Part D and a second category related to Part B drugs. Today, we're going to focus on the first category: negotiated rebates and fees that Part D plan sponsors receive after the point of sale that reduce plans' costs of providing pharmacy benefits. CMS refers to those data as direct and indirect remuneration, or DIR.

These are price concessions that plan sponsors negotiate with manufacturers and pharmacies but do not reveal publicly, and for that reason they're proprietary. The law that gives the Commission access to these data and also lays out disclosure limitations that affect how much detail we can provide

You saw this last October, so I'll just refresh your memory. Here we're depicting a simplified pharmacy transaction. When a beneficiary fills a prescription, she pays the pharmacy her required cost sharing while her plan and its pharmacy benefit manager, or PBM, pay the pharmacy an agreed upon amount.

However, after the prescription has been filled, if the plan and PBM have a rebate contract with the manufacturer of that drug, they collect a rebate. The plan and PBM may also pay or collect a fee from network pharmacies based on performance metrics or other contingent payment agreements, referred to as pharmacy DIR. Pharmacy DIR can be positive or negative, but it mostly flows from pharmacies to plans. The thing to note from this slide is that the price for a prescription at the point of sale doesn't reflect final costs to a plan because there are

rebates and fees that take place after the transaction.

CMS requires plan sponsors to submit DIR data annually for each of their plans, including any price concession that decreases costs of providing Part D benefits. In Part D, Medicare makes several types of prospective payments to plan sponsors based on what they bid as the cost of providing benefits. CMS uses the DIR amounts to true up or reconcile what Medicare made in prospective payments compared to plans' actual final costs.

Plan sponsors submit two separate types of DIR reports, summary and detailed. Summary reports provide top-line, plan-level data on different categories of DIR. Detailed DIR reports have plan-level information that is reported on a drug-by-drug basis. CMS provided the Commission with both sets of reports for Part D plans covering the years 2010 to 2020.

Here's the top line. The aggregate amount of DIR has grown from $8.7 billion in 2010, which was about 11 percent of total Part D drug spending, to $53.6 billion in 2020, or 27 percent of gross spending. So over time, growth in rebates and fees has widened the gap between prices at the pharmacy and benefit costs net of DIR.

Manufacturer rebates, which are shown in blue, make up the vast majority of DIR and have grown dramatically. However, rebates' share of total DIR has declined over time because the second largest category, pharmacy DIR, in yellow, has grown even more rapidly. By 2020, pharmacy DIR total $9.5 billion and made up nearly 18 percent of all DIR.

There are other types of DIR such as risk-sharing arrangements, legal settlements, and administrative fees, but those categories remain a very small proportion of the total.

After CMS sent the Commission DIR reports, we first conducted checks of data validity. There are no public sources of data to test external validity. We can't open the books of plan sponsors to see if what they've reported to CMS is accurate. Instead, we looked to see if the data were complete and consistent with other published information. I'll summarize our tests here, but your mailing materials go into detail.

We checked whether DIR data provided to the Commission reflect all Part D plans and found that generally they capture all plans that are required to

submit DIR reports and those plans cover nearly all Part D enrollees. We found that DIR amounts in the data provided to the Commission were consistent with other published totals such as those of the Medicare trustees. We checked to see whether the amounts of DIR were consistent in the two separate types of reports than plan sponsors submit, and yes, the amounts in summary DIR reports agree with those in detailed DIR reports. Finally, as Bruce suggested last fall, we compared the DIR data provided to the Commission with reports CMS prepares when it reconciles Medicare's prospective payments with final plan benefit costs. We found that those amounts were largely in agreement.

The next several slides show our initial data analyses. These were designed to comply with the law that gave the Commission access to these data, which placed restrictions on disclosure of information.

To try to understand the growth in DIR, we compared concentration in enrollment with concentration in the amounts of DIR received by plan sponsors. Larger sponsors typically own their own PBM, mail-order, and specialty pharmacies and are thought to have more

negotiating leverage with drug manufacturers and pharmacies. We looked to see whether companies with the most Part D enrollees also obtained greater shares of all DIR.

The blue bars in the figure on the left show the shares of all Part D enrollees in plans operated by the top 10 Part D plan sponsors ranked by enrollment, including both stand-alone and Medicare Advantage prescription drug plans. You can see that between 2010 and 2020, which was a period of lots of mergers and acquisitions of PDMs, enrollment became more concentrated. The lighter blue bars show the share of all DIR that those sponsors received, which was even more concentrated than enrollment, especially in 2010 and 2015.

In the figure on the right, the dots represent DIR as a percentage of gross plan spending. You can see that the top 10 sponsors, in blue, were able to negotiate proportionately higher DIR than their smaller competitors.

As the Commission looks at Part D issues, it's important to recognize the relevance of both gross Part D spending and net spending. Gross spending, meaning prescriptions measured at pharmacy prices, is relevant to

beneficiaries because many of them pay cost sharing in the form of deductibles or coinsurance that's a percentage of pharmacy prices. Gross spending is also relevant to Medicare subsidies for low-income cost sharing. That higher cost sharing has implications for how quickly enrollees move through Part D's benefit phases and reach its OOP threshold.

Spending net of DIR is what is most relevant to Part D plan sponsors as they put together their bids for the cost of providing benefits, which in turn affects how much enrollees pay in premiums. We also focus on spending net of DIR because Medicare makes monthly capitated payments and low-income subsidies that pay for plan premiums, and Medicare keeps a share of DIR to offset some of the cost of reinsurance it pays for claims above the out-of-pocket threshold.

Over many years, the Commission has used Part D claims data to construct price indexes that show trends in gross prices at the pharmacy. With the help of a contractor, we used plan sponsors' detailed reports that provide DIR amounts on a drug-by-drug basis to develop indexes of drug prices net of rebates. Your mailing

materials go into more detail about methodology. This figure shows indexes for brand-name drugs at gross prices, in blue, and net of manufacturer rebates, in orange.

Rebates vary a lot for any individual drug. Some receive no rebates whatsoever, while in other drug classes it's typical to see more than half of the gross price rebated by the manufacturer. These indexes reflect the overall difference between gross and net for the mix of brand-name drugs used by Part D enrollees. You can see that between 2010 and 2020, the index for brand drugs net of rebates has a value of more than 2, indicating that overall, brand prices more than doubled over that period.

And now Shinobu will take a look at drug classes.

MS. SUZUKI: Until now, our understanding of which drugs are contributing to Part D's program costs have been based on gross spending. However, as Rachel noted, manufacturer rebates vary widely across therapies. So, we ranked therapeutic categories of drugs by spending with and without rebates to see how they compare.

Interestingly, in 2019, the same therapeutic categories made the top 15 list based on gross and net spending, but manufacturer rebates affected the rank order

for 10 of those categories.

Ranking based on net spending fell for therapeutic categories with higher average rebates, for example, anticoagulants, and rose for categories with lower average rebates, for example, antineoplastics.

There are different classification systems for therapeutic categories. Under the drug categories we used, 7 out of 15 were in the so-called protected classes. These included 3 categories of antineoplastics and categories such as antivirals and antipsychotics. The protected class policy requires sponsors to include "all or substantially all drugs" on their formularies, and we have been concerned that this requirement for broad coverage may limit plans' ability to obtain manufacturer rebates.

A few slides ago, you saw both gross and net prices of brand-name drugs more than double between 2010 and 2020. Over the same period, Part D spending for brand-name drugs also grew rapidly, but that was driven primarily by the rapid growth in spending for higher-price drugs.

The figure on the left shows gross spending for 2010 and 2020, separately for brand drugs with prices below $700 and those with prices at or above $700. Note that the

price category we are using here is based on gross prices at the pharmacy. The cutoff point of $700 roughly corresponds to the threshold CMS set for drugs that were permitted to be placed on a specialty tier during this period.

These drugs that plans could place on a specialty tier often treat rare diseases and have fewer therapeutic competitors. That, in turn, allows manufacturers to set high prices and limits plans' ability to negotiate rebates.

Looking at the first set of bars on the left, between 2010 and 2020, gross spending for drugs with prices below $700 grew from $49 billion to $74 billion, or an average annual rate of 4 percent. For drugs with prices at or above $700, spending grew from $8 billion to $84 billion, or an average annual rate of 27 percent. The figure on the right shows spending net of manufacturer rebates.

Between 2010 and 2020, net spending for drugs with prices below $700 decreased slightly, while for drugs with higher prices, net spending grew by an average annual rate of 25 percent, 2 percentage points lower than the growth in spending before accounting for rebates.

Overall rebates, however, have grown rapidly since 2010. Manufacturer rebates totaled $43 billion in 2020, up from $8.5 billion in 2010. The figure shows, for 2020, aggregate gross spending and rebates for drugs with prices at or above $700 in blue and those with prices below $700 in gray. This figure highlights how a disproportionate share of rebates was for drugs with prices less than $700.

Brand drugs priced at or above $700 accounted for 53 percent of aggregate gross spending and 21 percent of all rebates, while brand drugs priced below $700 accounted for 47 percent of aggregate gross spending but nearly 80 percent of all rebates.

This table shows how the availability and the magnitude of rebates differed by price. Note that these are averages and rebates varied widely even within the same price category. In general, in 2020, fewer and proportionately smaller rebates were available among products with higher prices. We found that the share of products with rebates ranged from 15 percent for the highest price category, to 55 percent to 58 percent for drugs with prices below $700.

Among the rebated drugs, rebates as a share of gross spending ranged from 11 percent for drugs in the highest-price category to 51 percent for the lowest-price category. While proportionately smaller, rebates for some high-price drugs could be substantial.

However, for the majority of high-price drugs, what this suggests is that plans may have little or no leverage to negotiate rebates. After many widely used drugs lost patent protection around 2012, manufacturers launched many products that treat relatively smaller patient populations, sometimes with fewer therapeutic competitors. That in turn gives manufacturers greater ability to set higher prices or to raise prices over time.

To summarize, DIR amounts provided to the Commission appear to be complete and consistent with other published totals. We found that the largest plan sponsors received proportionately more DIR.

In our initial data analysis, we found that, in 2019, therapeutic categories that had the highest gross spending also had the highest net spending, but manufacturer rebates affected the rank order.

We also found that, between 2010 and 2020, Part D

prices for brand-name drugs more than doubled and spending for high-priced drugs grew rapidly, even after accounting for manufacturer rebates.

Finally, we found that, in 2020, higher-price drugs had fewer and proportionately smaller rebates. Some high-priced drugs had substantial rebates but, in general, this suggests that many of the high-priced therapies may lack therapeutic competition.

Going forward, we plan to explore the relationship between therapeutic competition and manufacturer rebates and examine patterns in plans' reporting of the DIR data. Findings could help us discern how much confidence to hold in the plan-level data, and will be important in formulating research questions and interpreting the results of our analytical work.

We are looking for Commissioner feedback and suggestions for the direction of the future research. With that, we will turn it over to Mike.

DR. CHERNEW: Terrific. This is super exciting. Again, we are at the beginning of all we can do, and I think the theme we are about to have is what can we do.

So I know we have some Round 1 questions. Dana,

do you want to go through the queue?

MS. KELLEY: Yes. We have Bruce first.

MR. PYENSON: I've got two quick questions. On Slide 12, is the $158 billion gross spending, is that just brands or is that brand and generic?

MS. SUZUKI: So the 158 is for brand-name drugs, and I believe we limited it to ingredient costs only on the pharmacy claims.

MR. PYENSON: Thank you. In the text of the paper you mentioned the PACE program report zero rebates. Do you know why?

DR. SCHMIDT: It's not clear that it's every PACE program, but we mentioned that those that do have zero rebates don't have to submit the detailed report. And no, we do not know why that might be the case but we're happy to look into it.

MS. KELLEY: Amol?

DR. NAVATHE: A quick question on Slide 7. I'm curious if we have looked at or if we are planning to look at -- so this is the top 10 plan sponsors analysis -- how these plan sponsors, how this relates basically to premium growth even within those plan sponsors, given that they are

getting larger rebates. And I'm assuming we haven't looked at it because you haven't described it, but I was just curious if that's part of what we plan to look at.

Sorry. I was asking for the top 10 plan sponsors analysis, if we've looked at how that relationship is affecting or relate to premium growth, and if we haven't looked at it, if we're planning on looking at that.

DR. SCHMIDT: Well, one of the last things that Shinobu ended on is that a next step we need to do initially is kind of look in a little more detail at the allocation of rebates among the plans to see if we find that reliable, and if there are some obvious patterns that seem to make sense or if there are patterns that raise our eyebrows that might have implications for the degree to which we can do the sort of analysis that you are suggesting.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: Thanks, and first off just a great chapter, and echoing Mike it's exciting to be on the launching pad here of being able to do some analysis.

Could you go back to Slide 12? I just wanted to clarify -- I think it was 12. Next slide. Yeah, there we

go. So it looks like for the lower-cost drugs for plans between 2010 and 2020, essentially, their spending stayed pretty flat, but beneficiaries would not have captured any of that. Is that right? So beneficiary spending would have gone up even for the lower-cost drugs.

MS. SUZUKI: Are you asking about the cost sharing?

DR. JAFFERY: Yeah, exactly.

MS. SUZUKI: So a lot of drugs in the lower price category tend to be in the co-pay category, at least during the initial coverage phase, so their co-pay increases over time but it's probably not to the extent of the actual price growth rate. And you see that it's flat when you're considering the net cost, and that shows how much rebate there were for these products. And those can be used primarily to lower premiums, so a beneficiary may benefit in the sense that they have lower premiums.

I think with higher-price drugs you do see a lot of drugs with co-insurance, and particularly once they get to the coverage gap most brand-name drugs are going to be co-insurance rather than co-pays that they paid in the earlier phases of the benefit. So regardless of gross or

net cost we see huge growths, but gross price is going to drive their co-insurance.

DR. JAFFERY: Gotcha, and I get the point about co-pay versus co-insurance, and that is very helpful. Thanks.

MS. KELLEY: Pat.

MS. WANG: Thank you. Are you able or did you have a chance to examine different -- so this is all Part D spending -- differences as between standalone Part D plans and MAPDs, or that something that's planned? Are you able to segment like that?

DR. SCHMIDT: So this is similar to Amol's question in the sense that we have data on a plan level, so the PBP level. So we have plan sponsors that are submitting it and there is some discretion in how they allocate the total amount of DIR that they're getting from manufacturers and from pharmacies to each of their plans.

So our next step must be to look at whether we're observing patterns that make sense and how they've gone about doing that allocation. And that, in turn, will have implications for whether we can do the sorts of breaks that you're thinking of by MAPD versus PBP, and so forth.

MS. WANG: So this is the top 10, which, as you mentioned, have a lot of vertical integration, so they have all of the pieces. There are a lot of freestanding -- but they're shrinking -- but there are still freestanding MAPDs. I presume you would not have the same internal allocation problems there because they don't have their own PBMs, or maybe I'm misunderstanding.

DR. SCHMIDT: So this is a matter of, say there is a plan sponsor that offers 10 different plans, and it could be a sponsor that only offers MAPDs, or three different plans. What they're reporting to CMS is their decision about how to take the DIR that they've received from manufacturers and pharmacies and allocate it among those at the plan level, and then more onto the detailed report, how they allocate that to a drug-by-drug level.

And so we need to look a little more closely at how plans have done that, to have some confidence in further analyses.

MS. WANG: Thank you.

MS. KELLEY: David.

DR. GRABOWSKI: Yeah, let me echo others. This is a great, great chapter and really exciting to get these

new data. It's like a kid in the candy store phenomenon here.

I understand from the presentation chapter that statute limits the level of detail we can look at, and I think I understand what we can't do. Could you give me like what we can't -- like what's the level that we can't -- so that it can be most helpful in making suggestions? I understand what is below the line. What is kind of above that line?

DR. SCHMIDT: Frankly, we are working our way through that. So, you know, as we showed in you some of the drug classwork there's lots of ways to slice and dice drug classes, with various degrees of granularity. And the lower you get, the more detail you're providing, and you can figure out who is who, right? So that's the tricky part, trying to figure out what level of drug class we can go to without revealing which manufacturers are at play. And the same is true for the plan sponsors.

DR. CHERNEW: I just want to make the distinction what we can do and what we can report. We can do a lot. We can draw conclusions that are broad. We just can't report, if I understand correctly, at that level of detail.

And we're about to go to Round 2, but if I have this correctly, David, you were the last one in Round 1. Is that right, Dana?

MS. KELLEY: I think Bruce had a question.

DR. CHERNEW: Oh, okay. I have to check my chat. Anyway, but the key point is, as we go through what to do, keep track of what they do, we will worry about what we can report, but I think drawing inference on what they can do is probably the most important thing, and then we'll figure out what we can actually say about it.

DR. GRABOWSKI: That's really helpful. Thanks, Mike.

MS. KELLEY: Go ahead, Bruce.

MR. PYENSON: A question related to Pat's question. Since many of the standalone PDPs or MAPDs contract with the dominant payers, how are you thinking of analyzing that?

DR. SCHMIDT: That is a very good point, and again we're working our way through it and open to suggestions. So we're looking over 2010 to 2020, is a long period of time, and there have been changes in who has had who as a PBM and so forth. So trying to even kind of

understand that time frame of which plan sponsors used which PBMs is part of this puzzle, which we're working on a bit.

MS. KELLEY: Larry.

DR. CASALINO: Just quickly, this is something I happily know little about, although I get the kid in the candy store phenomenon. But the work you will be able to do, will it shed more light on the relationship between plan sponsors and PBMs and what the pros and cons appear to be so far, the vertical integration between plans and PBMs, for example?

MS. SUZUKI: So I think we are definitely considering doing some exploratory analysis, looking at, for example, if a plan owns a specialty pharmacy -- PBMs own specialty pharmacies -- does that make the value of the benefit for or less for the beneficiaries compared to other plans that do not own specialty pharmacies, for example.

But I think we should caution you that there is a lot of information that we are not going to see with the Part D rebate data. For example, if the specialty pharmacies were receiving fees from manufacturers for providing some services, like providing data on patients,

that is not going to show up in the DIR data.

So there are lots of pricing issues that we do see now but there are also some that we won't see, even with all the granular data.

DR. CASALINO: Just PBMs and, to other extents, specialty pharmacies, I guess, and then the vertical integration of plans and PBMs and specialty pharmacies. It seems like such a big deal. But any use you could make of this data to help us and the world understand more about would be helpful.

MS. KELLEY: Do you want to go to Round 2? Okay. I have Stacie first.

DR. DUSETZINA: Thank you so much, Rachel and Shinobu. This report is awesome, and I don't think I could be more excited about access to the data and also what you've been able to produce so far, so thank you so much.

There were a couple of things that I thought, you know, at least broad strokes that we could think about. First, short-term for this current version of the report, the table where you have the top 10 sponsors, I think is a little bit different than the graphs that you showed in the presentation today, and I really like being able to see the

side-by-side DIR in each year for the top 10 versus not the top 10. I would love to see that brought into the report, because I felt like that piece was a little bit missing, or harder for me to get there with what we have in the report.

The other thing that I just had kind of wanted was the comparison of protected class drugs. And you did such a great job of showing the percent of brand share in that table, but I did wonder what happens when you pull out the products that have a generic available and kind of what is the impact on the average rebates there, when the ones with generic competitors are out completely from those estimates.

I think those are my two for this particular report but I had a couple of like longer-term wish list items for next steps, as you are probably not surprised. One is thinking about if there's a possibility of getting some information specifically for drugs that are going through specialty pharmacies, because that is missing from any of the available data sources that researchers have access to now. Those drugs aren't reported in SSR health data, for example, so that would be a huge service to the field.

Another that I think will be more complicated but really important is thinking about the role of competition. So if there's some way to look at predicting rebates based on, you know, you're the only brand in the class, you have two head-to-head, same mechanism of action, you know, all the rules that we set up in Part D, can we actually create these broad categories of how much competition there is and use that to predict an average rebate? Again, huge service to the field to be able to get more accurate about when we think rebates are likely in Part D and elsewhere.

And then, you know, I think that there are a lot of opportunities for thinking about looking at the drugs with the highest rebate and potential formulary decisions that may be bad for beneficiaries and for Medicare, the so-called rebate traps. You know, I know we can't identify individual products, but trying to figure out, is this really something that we should be worried about broadly, where a brand-name drug maybe has preferred placement over a generic in some cases, or higher-cost versus lower-cost drug?

And then Amol and I have been scheming a little bit over here about trying to get that question of the

rebates and how they're distributed to plans and thinking that if we're able to actually predict the rebates, create a formula to predict the rebate, you could then do that across all the plans and then predict what each plan's rebates would have been, based on actual drugs use, and see how discrepant that is from what is actually reported. So I'm going to sign us both up for helping with thinking through that.

But thank you both so much. This is incredible work, and I'm excited for how much this is going to move the field forward.

DR. CASALINO: Stacie, can you tell us what a rebate trap is? It sounds great.

DR. DUSETZINA: Conceptually it's basically that the brand manufacturer is paying such a high rebate that it incentivizes the plans to pick a drug that is kind of worse for the patient and worse for Medicare. So a brand-name drug over a generic drug is an example that will often be used.

I think that it's a little bit one of those things where you may be able to pick out a couple of examples where you can see that happening with Medicare

formulary coverage decisions, but I don't know if it's widespread but we've just not had the data to investigate it. So I think it would be a nice service to know if that's going on in a way that's more concerning and needs more regulation.

MS. KELLEY: Lynn.

MS. BARR: Thank you. What a fantastic report, and like everyone else I really enjoyed reading it.

The question that came to my mind, Medicare has offers of reinsurance for the catastrophic phase at 80 percent, and then seeing that they're actually making 27 percent margin. So we're reimbursing them above their cost during the catastrophic phase, which we would not have possibly known if we hadn't had this data.

So I was wondering, though, if you could do any modeling, because the rebates are all in the low edge, right, and people hit the catastrophic phase in the more expensive drugs. So have you guys thought about like how these things could interrelate?

DR. SCHMIDT: So just to be clear, CMS does some calculations to try to retain some of this DIR to offset some of the costs of the 80 percent reinsurance. So that's

part of the reason for doing a reconciliation process, after the benefit year has passed. So they get the DIR reports from the plan sponsors and when they're calculating the final reconciled amounts, Medicare does keep a portion of the DIR.

MS. BARR: What portion?

DR. SCHMIDT: It's roughly comparable to the share of spending that's above the out-of-pocket, or about 80 percent of that amount of spending.

MS. BARR: Okay. Thank you.

MS. KELLEY: Brian.

DR. DeBUSK: Actually, the timing was great. The one catch is the way they split that up. The beneficiary cost-sharing is included in the denominator of all spending, which diverts a little bit of that money. There's basically about a 20, 25 percent house vig that gets shifted towards plans and away from the reinsurance program.

You know I couldn't let that go.

First of all, I want to thank you both for a great chapter. It read really well and I was really excited to see us get the data. I cannot imagine the

difficulty that you guys are going through with some of the statutory requirements on this. So I feel your pain. I can't imagine having to do an analysis and get a legal review on it before you can even send it out the door, but I suspect it's probably what you're looking at.

You know, the rate of increases is alarming -- I mean, 28 percent -- and especially when you consider, and I want to touch on something Stacie mentioned, there are number of drugs that aren't even subject to rebates because they either are in protected classes or they have no competition. So building on Stacie's comment, if we could develop some type of competitiveness index of some measure, is this a patented drug, is it in a protected class, because it would be fascinating to see how these rebates track with some predictor of competition. You know, should we expect the competition that we just don't see? So again, I'm really, really interested in that.

Also, I do realize the data has some limitations, and this is just sort of a standard plug. I do think it is incumbent on us to be really good stewards of that data and do some interesting things with it, because I think it positions us well to ask for more information.

And I did have a specific question. On page 9, you mentioned that there are some allowable approaches to how they can allocate the DIR at the plan level and at the NDC level. You know, we might want a text box -- I'm thinking in a report -- that just has a brief description of what those allowable methods are, and we may want to start tracking that now, not that we're going to ask for wholesale reform. But I think what's going to happen is as you use this data, we're going to need them to narrow those allocation methods closer and closer to a standard to make the data more and more useful, and it wouldn't hurt to have some visibility around what the methods are now and then bring that together.

I did notice that there does seem to be the ability to allocate DIR at the plan level, that maybe even affect our next discussion on segmentation, because I suspect that that enhanced Tier 1 plan is probably where a disproportionate amount of DIR is being directed.

But I also was really interested at the NDC level. You know, again, I really hope that we can standardize that and have a treatment that makes the data even more useful.

I do have a question, and it's not rhetorical. This is legitimate, but it's bothered me. I noticed in the materials, again, page 9, it mentioned that the manufacturers mainly get, or PBMs may negotiate a combined rebate across multiple drugs for DIR. And my concern there was if it's a drug that spans multiple categories, isn't that a tying arrangement? And again, this isn't rhetorical. I truly don't know. It is a tying arrangement, and does the fees discount and safe harbor provision exempt these companies and allow them to engage in tying arrangements?

Look at me with a Round 2 question, by the way.

But no, seriously, I don't understand the mechanics of that, but it seems like there's some practices that are already established to protect against things like that.

And then I have one final long-term ask, and then I'll go to my Round 2 question. You know, it would be interesting -- and again, I think Stacie touched on this -- to be able to look at the nature of the rebates. You know, which rebates are proportional? You know, when you go to a customer and say, "I want you to have a 10 percent better

price because you're a great customer," that's a beneficial rebate, as far as I'm concerned. If you go to that same PBM and say, "If you list my competitor's biosimilar, I'm going to strip you of all the rebate on this drug, from dollar one, just simply for listing it," you know, that's more of a predatory rebate to me. I mean, it seems like continuous rebates are probably good. Discontinuous rebates could be predatory.

And this is the long-term ask here. It would be really interesting to see the Commission try to build a framework around what are beneficial rebates versus predatory rebates, and try to give Congress some almost framework for good versus bad rebates, because normally when this question comes up there's this false dichotomy of, well, we're either going to throw all the rebates out or we're going to keep all the rebates. And it seems like there's a Choice C in this.

Thank you, and again, great chapter.

MS. KELLEY: Bruce.

MR. PYENSON: Thank you for a great chapter. I would like to suggest a table in addition to the ones that you have now, that puts together the transition from gross

to net, because there's so many parties or stakeholders along the way, and to separate that between the rebatable brands and the no-rebate brands in some reasonable way. I know it's going to vary. And start with the gross spend. And then to show the coverage gap discounts, because coverage gap discounts perhaps could be thought of as a statutory rebate. And then the rebates that you know, and then cost share which the patients are paying, and then the share of catastrophic that the government is paying, and at the end the net spend. So it would kind of start with gross and go to net, then the pieces that the manufacturer is paying off of gross coverage gap discount would affect both the rebated and non-rebated. The rebates, of course, would affect just the rebates, cost sharing, and so forth.

So I think those six columns would have a huge amount of information that could be inferred from that, and could do that for everything in total or do it just for the LIS or do it for EGWPs, or do it for enhanced plans, do it for MA versus PDP.

Thank you.

MS. KELLEY: Amol?

DR. NAVATHE: I think I can be relatively quick,

because I think many of the comments that I wanted to make have actually been covered by other Commissioners.

First off, great work. I'm super excited to see this go forward.

I think there are a number of different next steps that have been articulated. I just wanted to kind of echo a couple of them where I think one area which I think is broadly outlined is just the discrepancies that this can create on cost sharing for patients, and how these rebates in general are passing through to premiums and/or on the cost sharing side in potentially offsetting ways. I think to the extent that we can understand that best, I think that would be a particular priority.

A second point is, and this is somewhat related to what Stacie was suggesting, it would be interesting to see how we can sort of empirically come from a bottoms-up approach. So there are areas like the cost-sharing, there are areas like protected class, where I think we are predefined based on benefit design or the kind of Medicare policy around, it would be good to understand how DIR varies across these categories.

Another question is if we basically think of more

or less all the observable characteristics that we could do, could add to a multivariable model to then best understand what is associated with high versus medium versus low levels of DIR, that could be a very nice latent model, not something that we would publish but a latent model that we could use to do a variety of different things, including some of the predictions that Stacie and I were discussing on the plan piece. But, in fact, I think we could use that to study many different aspects of how the rebates are actually functioning in practice.

So Stacie and I, I think, are happy to talk more about that, but I think that would be a nice, empirically driven approach, as opposed to having to think up every perfect analysis before we touch the data, conceptually.

Thanks.

MS. KELLEY: Pat.

MS. WANG: Thank you. I think it's been said, and I just want to sort of voice my support. It sounds very complicated, but I'm hoping that you really can get to the point and sort of prioritize being able to look at PDP and MAPD separately, both MAPD within the large plan sponsors and vertically grated organizations and

freestanding. And then within that subset I really want to encourage a closer look at D-SNPs and the LIS population. The observation, which I guess is not a surprise, about low DIR in the protected classes, because there's no competition--why should you offer rebates of any magnitude?--the presumably much higher utilization of protected class drugs by the LIS population, and also just the formulary design or the design of Part D for the LIS population, which we spent a fair amount of time talking about in connection with the 2020 Part D chapter, you know, the lack of tiers, the lack of cost sharing for a very large portion of the LIS population and de minimis cost sharing for others in the form of co-payment, co-insurance, which really impedes a dual SNP's ability to even direct utilization of lower-cost drugs.

I just think that it could be extremely rich information that could help people figure out whether the LIS drug design is optimized, both for the beneficiary but also from a cost perspective, because right now, given the disproportionate share of dual eligibles who are enrolling in D-SNPs, and LIS beneficiaries who are enrolling in D-SNPs, and the importance of the MAPD program for that

population, I think the more information we can reveal about that, the better.

The other thing is just a curiosity. I have no idea if this is even possible or makes sense. But for the dual population, you know, a drug used to be covered by Medicaid programs until Part D restructured everything. Medicaid programs have their own statutory rebates. Just would be curious if we could ever get to the point of understanding for the LIS Part D spend how that would actually compare to what states still have in place for their statutory Medicaid drug spending. Just to know. I don't know if it's possible to get at that.

And so that's lots of curiosity about digging deeper, which I think people have mentioned about the fact that larger sponsors are getting more DIR, does that ripple down to the MAPDs that they sponsor, et cetera, et cetera.

As you know, I do think that MAPDs make different formulary decisions. You know, DIR is an important factor, but things like medication adherence and overall health that an MAPD is responsible for, that a PDP is not, really results in different formulary decisions. So I really think that it would be worthwhile to try to understand how

that results or does not result in different levels of DIR.

I think it's really exciting that you're doing this work, and it's just tremendous important, so it's great. Thank you.

DR. CHERNEW: Jon Perlin.

DR. PERLIN: Let me add to the chorus of accolades for you work. You know, unraveling this Gordian knot with one hand tied behind your back is quite a feat, so thank you for the work on this.

My question/comment really extends from Stacie's on rebate traps and Brian's points about predatory and non-predatory effects and the discontinuities created. And, you know, when you outlined patterns of DIR growth over time and for certain effects of consolidation, et cetera. But I'm wondering about any patterns related to the lifecycles of the drugs themselves, as to maybe temporal patterns that are positive or less positive in terms of the effect on what we're interested in, the beneficiaries themselves. Are there effects that are seen at product launch? Are there effects that are seen at the point of entrant of a new competitor?

It is really, I think, in those sort of temporal

aspects we're making insight into points at which the incentives overwhelm other factors in terms of utilization and perhaps even the best or most optimal utilization patterns. And I realize it's probably nudging the boundaries of restrictions in the data use, but I'm hoping that there are ways to get there.

But to be transparent on this, as I said, my point is what are the impacts of this on the Medicare beneficiary in terms of potentially initiative a new therapy, potentially created a loyalty, potentially increasing switching costs. And I don't mean switching costs just in terms of the cost of the drug itself, but switching costs, for example, in terms of having to get another doctor appointment, et cetera, and all the things that are necessary as cascade to effectively be all but locked into a particular medication.

So again, terrific work, and I look forward to seeing what stems forth in the future. Thanks.

DR. CHERNEW: Dana is looking at me to note that that is the end of the Round 2 queue, if I have it right, and I think we do. So I'm going to look around. That was, I think, a very useful discussion. There's obviously a lot

to do. We will be seeing versions of this for a long time. I'm sure you will send your comments.

To those at home, or wherever you happen to be, we do recognize this is our new version of a public meeting. We are able to reach a lot of you by Zoom, and we can still have lunch, which we're about to have together. In that spirit, please send us your comments. We really do want to hear them. You can send an email to meetingcomments@medpac.gov, or you can go to the website and go to Public Meetings and then look at past meetings and send us a comment. We really do want to hear. This issue of prescription drugs broadly is one that I'm sure attracts a lot of attention, and we would like to hear the reactions of the public.

So with that, barring any other comments, we are going to adjourn. We will come back and talk about prescription drugs after lunch, Part D in this case. But we really do appreciate everybody who has joined us remotely, and we'll see you at 2.

[Whereupon, at 12:32 p.m., the Commission was recessed for lunch, to reconvene at 2:00 p.m. this same day.]

AFTERNOON SESSION

[2:01 p.m.]

DR. CHERNEW: Welcome, everyone, to our afternoon session of the MedPAC meeting. We're going to jump right in. Eric is going to take us through a

discussion of segment in the stand-alone Part D market. And so, Eric, we're looking forward to this. It's all to you.

MR. ROLLINS: Thanks. I'm going to start the afternoon with the last of our three sessions on prescription drugs. This time we're going to look at Part D's stand-alone prescription drug plans, or PDPs. This is a follow-up to a session at the September meeting that looked at benchmark PDPs that serve beneficiaries who receive the low-income subsidy. This time we take a broader look at the PDP market and how insurers offer multiple plans to divide it into distinct segments. Our goal today is to assess your interest in doing more work on this issue during the next meeting cycle.

The material from today's presentation, along with some material from September, will appear as a chapter in our June report. Before I begin, I'd like to remind the audience that they can download these slides in the handout section on the right-hand side of the screen. I'd also like to thank Tara Hayes, Rachel Schmidt, and Shinobu Suzuki for their help.

Let me start with a little bit of background.

PDPs provide drug coverage to beneficiaries in the fee-for-service program, and now cover about 19 million people. All PDPs provide either basic or enhanced coverage. Basic coverage is the standard Part D benefit defined in law or alternative coverage with the same value, while enhanced coverage consists of basic coverage plus some type of supplemental benefit. Medicare subsidizes the cost of basic coverage, while enrollees pay the full cost of any additional benefits through a supplemental premium.

CMS does not allow insurers to offer more than three PDPs in a region -- one basic plan and two enhanced plans. Insurers must also demonstrate that their enhanced plans have "meaningful differences" from their basic plan to make it easier for beneficiaries to understand their coverage options, and your mailing materials have more detail on how this requirement has evolved over time and how it's enforced.

When insurers design their PDP offerings, there are two key considerations that affect their decision-making. The first is the design of the low-income subsidy, which only pays for basic coverage and only up to a specific dollar amount known as the benchmark. Given this

design, plans want to maximize the revenue they receive for LIS enrollees by keeping their premiums just below the benchmark.

The second is the behavior of people who do not receive the LIS. These beneficiaries are typically sensitive to premiums when they first pick a PDP but rarely switch plans after that. This behavior pattern gives insurers an incentive to offer low-premium plans that attract new enrollees and then raise premiums later when the plans are older and have an established base of enrollees.

These goals are somewhat at odds with each other. Insurers would like to charge higher premiums to some beneficiaries and lower premiums to others. The ability to offer multiple PDPs makes it easier for insurers to meet these competing goals because they can tailor each plan to serve certain types of beneficiaries and thus segment the market. Most major insurers in the PDP market currently offer three plans and follow the same general strategy, which involves using their basic plan to target LIS beneficiaries and their enhanced plans to target other beneficiaries, with one plan focused on those with low drug

costs and the other plan focused on those with high drug costs.

This strategy leads insurers to price their plans in a very distinctive pattern. Here are the premiums for 2022, by region, for the PDPs offered by four of the largest insurers. The x-axis on these graphs is the Part D region number; there are 34 regions in all. The green line is the basic plan and the red and orange lines are the enhanced plans. Premiums are a key factor for many beneficiaries when selecting a plan, especially those who have low drug costs and do not receive the LIS, so insurers want to offer a low-premium plan to attract these beneficiaries.

In theory, the basic plan should be the low-premium option since it has no supplemental benefits. However, as we discuss in the mailing materials, more than 90 percent of LIS beneficiaries are in basic plans, and insurers would like to maximize their revenues for them. So sponsors instead use an enhanced plan, shown in red, as their low-premium option despite its supposedly richer benefits. Segmenting the market in this fashion lets insurers offer a low-premium plan without affecting the

revenues they receive for LIS enrollees. Insurers also offer a second enhanced plan with substantially higher premiums than the other two plans.

Insurers can take a variety of steps to differentiate their plans, and the mailing materials examine in some detail how the three types of PDPs differ. At a high level, the low-premium enhanced plans offer favorable coverage of certain generics by doing things like waiving the deductible and having $0 copayments. Their cost-sharing rules also provide stronger incentives to use preferred drugs and preferred pharmacies.

These plans also make targeted changes to their formularies, such as adding older drugs to meet the meaningful difference threshold and narrowing coverage in some key therapeutic classes. Since these are enhanced plans, they charge a supplemental premium, but it is typically lower than the meaningful difference threshold. To provide an extreme example, the threshold for this year was $22 per month, but the average supplemental premium for one of Humana's enhanced plans is less than $1. Finally, newer plans can make more optimistic assumptions about their enrollee mix in their bids, which can make it easier

to offer a low premium.

In contrast, the high-premium enhanced plans are much more likely than other PDPs to completely eliminate the Part D deductible. Compared to other plans, their cost-sharing rules tend to provide weaker incentives to use preferred drugs or pharmacies. They also have broader formularies, and their supplemental premiums are usually higher than the meaningful difference threshold. In effect, the enrollees in these plans pay higher premiums in return for richer benefits and broader access, in terms of both drugs and pharmacies.

It's also worth noting that this three-plan strategy tends to follow a distinctive pattern over time. As we have seen, insurers use low-premium enhanced PDPs to target beneficiaries who have low drug costs and do not receive the LIS. However, the premiums for these plans tend to rise over time. To some extent, premiums can increase when a plan's enrollees turn out to be sicker than insurers projected, or when costs rise for enrollees because their health gets worse over time. However, studies have also found that this pricing strategy is profitable because beneficiaries rarely switch plans and

insurers can raise premiums more easily for older plans with an established base of enrollees.

Insurers can meet these competing goals by pairing a newer, low-premium plan with an older, more established plan with higher premiums. As premiums for the newer plan rise, its ability to attract new enrollees decreases. When this happens, insurers can consolidate their existing enhanced PDPs into a single plan and launch an entirely new, low-premium plan. This dynamic does not apply to basic PDPs because many of their enrollees are LIS beneficiaries and insurers cannot offer more than one plan.

Let's look now at some implications of segmenting the PDP market. For insurers, segmentation makes PDPs more profitable because they can charge higher premiums for basic plans and older enhanced plans. As a result, segmentation also increases total program spending, although in both cases the magnitude is unclear.

For beneficiaries, the implications are more complicated. In some ways, segmentation makes it harder to understand your coverage options. Even with the meaningful difference requirement, the common-sense distinction between "basic" and "enhanced" plans has been lost and it

can be difficult to determine what extra benefits some enhanced plans provide. There's also less cross-subsidization between enrollees with low drug costs and those with high drug costs. That benefits healthier enrollees by giving them more access to low-premium plans but also results in higher premiums for sicker enrollees.

I'm now going to switch gears a bit and discuss three policy options aimed at addressing some of the problems caused by segmentation and the tradeoffs they would involve. The first option would modify how the meaningful difference requirement is administered. Under the current approach, insurers can meet the requirement by making changes to their formulary that have little practical effect, such as adding older medications, and as a result insurers can offer low-premium enhanced plans that provide little added value over basic coverage.

We think there are two potential reforms that might be worth considering. The first would be to remove LIS beneficiaries from the model CMS uses to evaluate meaningful differences. Very few LIS beneficiaries enroll in enhanced plans, so removing them would make the model's estimates more reflective of the beneficiaries that

actually choose between basic and enhanced plans. The second would be to require enhanced plans to cover some minimum percentage of the beneficiary cost sharing for basic coverage. These changes would not reduce segmentation directly, but they would help ensure that all enhanced PDPs provide some minimum additional value and make it more difficult for sponsors to offer low-premium enhanced PDPs.

The second option, which Bruce mentioned at the September meeting, would reduce segmentation by modifying the auto-enrollment process for LIS beneficiaries. Right now, LIS beneficiaries who do not select a plan are assigned exclusively to basic PDPs. Under this option, they could instead be assigned to enhanced PDPs that had lower premiums for basic coverage. When LIS beneficiaries are assigned to an enhanced PDP, the plan would provide basic coverage only, without any supplemental benefits.

In theory, this option would reduce program spending by auto-enrolling some LIS beneficiaries in PDPs that have lower premiums than basic plans. However, it may not work well in practice. The low-premium enhanced plans that are now available have low premiums partly because

they manage drug spending more tightly using features like higher cost sharing for nonpreferred drugs and nonpreferred pharmacies. Those features would not be as effective with LIS beneficiaries since the LIS covers most of their cost sharing. As a result, the premiums for these enhanced plans would likely increase if they received LIS auto-enrollments, which would reduce any savings and could result in more LIS beneficiaries being reassigned to new plans.

That brings us to the third option, which would reduce segmentation more directly by changing the rules that govern the number and type of PDPs that insurers can offer. Under this option, insurers would be required to treat their PDP enrollees as a single bloc, or risk pool, for the purpose of providing the basic Part D benefit. They would submit one bid for their entire PDP population in a given region, which means that every enrollee would pay the same premium for basic coverage and have the same formulary, cost-sharing rules, and pharmacy network. Insurers would still be allowed to offer enhanced coverage, but this would be done through optional "riders" that beneficiaries could purchase to supplement their basic

coverage. CMS discussed this approach in 2014 as a potential area for future rulemaking but didn't pursue it further.

Here's an illustrative example of how this option would work. The current approach is shown on the left, with an insurer offering three PDPs: a basic plan, a low-premium enhanced plan, and a high-premium enhanced plan. Each plan is a separate risk pool, with its own bid, formulary, cost-sharing rules, and pharmacy network. The mix of enrollees in each plan differs, and their premiums for basic coverage range from $15 to $45. When beneficiaries enroll in an enhanced PDP, they buy its basic coverage and supplemental coverage as a combined package. Under the alternative, the insurer would submit one bid for its entire PDP population and all enrollees would have the same basic coverage with a $30 premium. The current distinctions between the insurer's plans would largely be lost because all enrollees would be in the same basic PDP. Beneficiaries who wanted additional coverage could buy a rider and pay a supplemental premium. In this example, the insurer offers two riders, one with a $5 premium and one with a $20 premium.

With a single risk pool, insurers would no longer be able to segment the PDP market to increase profits or program spending. There would be a clear hierarchy where basic coverage is always the lowest-cost option and enhanced coverage is always more expensive, which could make it easier for beneficiaries to understand how their coverage options differ. Relative to the current system, enrollees who are now in low-premium plans would pay higher premiums, and enrollees who are now in high-premium plans would pay lower premiums. The need to keep premiums competitive would give insurers more incentive to manage drug spending for LIS enrollees, but this would be easier if the LIS cost-sharing rules were changed to encourage beneficiaries to use less-expensive drugs, which is something the Commission has previously supported. Finally, policymakers would need to decide how much flexibility insurers would have in designing the optional riders, and the level of beneficiary interest in them is unclear.

That brings us to the discussion portion of the session. First, we'd like to know if you think segmentation is, on balance, a problem in the stand-alone

PDP market. As we noted earlier, segmentation is problematic in several ways, but it also benefits some enrollees by giving them more access to low-premium plans. If you do think segmentation is a concern, we'd like your feedback on the three policy options we outlined, especially the last option that would require insurers to treat their PDP enrollees as a single risk pool, and whether you're interested in doing any additional work on this issue during the next meeting cycle.

That concludes my presentation, and I'll now turn it back to Mike.

DR. CHERNEW: Great. So I'm hoping we have a robust discussion of this whole area. I know we do have a queue, so Dana, I'm going to turn it over to you to manage the queue.

MS. KELLEY: Okay. I have Bruce first for Round 1.

MR. PYENSON: Eric, this is really terrific work. I really enjoyed the chapter.

I've got two questions. The first one is on the evolution of this work. The chapter that we discussed some months ago was about the low-income benchmark with the view

that perhaps the low-income benchmark was too high. And now that focus isn't mentioned very much in the report, and now it's about segmentation.

Could you explain the evolution? That's the first question.

MR. ROLLINS: Sure. So in September we had sort of a narrower focus, not just on the PDP market but on a very particular slice of it, the subset of plans that focused on LIS beneficiaries. And we discussed the incentives that plans have to kind of keep their premiums just below the benchmark, and I showed this graphic that if you show, like, you know, a graph, the difference between the premiums for these plans and the benchmark in their region there is this big bulge around the benchmark. Plans are all acting to sort of hit the same target.

And I think the discussion that we had at that meeting was I think there was sort of some general consensus that that was problematic, and they recognized their incentives for plans to not bid as competitively as they could. We outlined some potential options for addressing that, mostly in the spirit of giving more auto-assignments to plans that submit lower bids. But I think

there was a lot of uncertainty about sort of the instability caused by that, sort of what the impacts would be on beneficiaries and plans.

And so I think there was some agreement on, yes, there is a problem, but not a consensus on sort of what policy options we could support to address it. And I think there was also sort of this sense of like, you know, this is only one slice of what's going on in the PDP market. So this time around it's a little bit more of a step back to sort of, here's how the LIS slice of the PDP market fits into the broader strategies that insurers had when they offer PDPs.

And I think you are correct that the policy options we discussed in this paper aren't as directly focused on the LIS, but I think at least, speaking for myself, there's a thought that to some extent these things could provide some more indirect pressure on plan sponsors to focus more on the LIS beneficiaries. For example, in a single risk pool, insurers would presumably still like to keep their premiums competitive so they can attract enrollment, and so they would have to sort of manage spending for their LIS beneficiaries along with their non-

LIS beneficiaries, which is not something they really have to do now because they split them into different plans.

Is that helpful?

MR. PYENSON: That is helpful and it leads right into my second question, which is, when we think about having the common risk pool how would that operate differently for plans that want LIS members and those that don't? And would there be potential for plans to, in effect, segment, that one division of a company is focused on LIS and a different division is focused on non-LIS?

MR. ROLLINS: Well I think in the market that we have now we have companies that are clearly interested in serving the LIS. They'll have benchmark plans in a lot of the Part D regions. Most of the major sponsors are sort of in this cap.

But then we also have a lot of your regional PDP sponsors, like your Blue Cross plans, rarely have benchmark plans. They seem not to be interested or they're not there. They're not interested in serving LIS beneficiaries or do not think they will qualify to get them. I can't quite separate those two motivations, but they don't, by and large, participate in the benchmark PDP market.

So we already have some of this, sort of. Some companies are interested in these beneficiaries and some companies are not.

In terms of administering the risk pool, I think our thinking was that this would be done at sort of the parent organization level, sort of the highest level of corporate control. Hopefully that would capture any subsidiaries that a company launched in an effort to sort of have a separate channel for serving LIS and non-LIS beneficiaries, which I think is kind of what you have in mind.

MR. PYENSON: Exactly. Thank you very much.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: Fascinating information.

So I'm a little confused. My understanding is that all PDPs had to offer a basic plan. My assumption was then that that basic plan would be part of the LIS pool of possibilities, but that's not true. I mean, in California we have 5 benchmark plans but we have 10 sponsors. So clearly not everybody is actually offering it, even though some of those plans, the enhance one or two, may be cheap, but obviously that still doesn't qualify. Cheapness

doesn't make you basic.

So maybe just clarify -- first question -- clarify. So all PDPs do not have -- and I think you said that just now -- do not have to offer a basic plan that LIS recipients could pick. They don't have to.

MR. ROLLINS: Correct. So under the Part D law, any company that wants to offer PDPs -- like I said, they can offer up to three different plans -- one of them has to be a basic plan.

MS. MARJORIE GINSBURG: And the definition of basic means --

MR. ROLLINS: The benefit package is what is set out in the Part D law or it's the actuarial equivalent. There is no supplemental benefits included with it. It's just sort of what's the standard Part D benefit. So every company has to do that, and those basic plans are the only plans that can potentially get benchmark status and receive auto-enrollment of LIS.

MS. MARJORIE GINSBURG: Because they are priced at a certain level.

MR. ROLLINS: Yes, but also the benchmark is essentially the average premium for basic coverage, right.

There's a range of premiums that basic plans offer. So the basic plans that tend to have more expensive premiums, they're going to be above the benchmark. An LIS beneficiary is not going to able to enroll in them for $0.

MS. MARJORIE GINSBURG: So the idea of making sure there was enough variety of plans for LIS is kind of -- we'll see. I mean, it isn't really true. You can offer basic but you price it so high that you're not going to meet the benchmark maximum per month. Is that right?

MR. ROLLINS: Well, I think the idea was that first off, since the LIS, within the dollar limit, pays your premium and covers most of your cost sharing, the thought was they don't need an enhanced PDP. The LIS is providing better supplemental coverage than any PDP on the market is going to provide. So a basic plan makes sense for the LIS population.

It was also an expectation that these were going to be the cheapest plans when Part D was set up. If there's no supplemental coverage, in theory they should be less expensive. And then even within that, policymakers wanted to sort of, you know, put them in sort of the more affordable plans, the less expensive plans.

So there are sponsors out there that can just have a very high premium for their basic plan and they won't qualify.

MS. MARJORIE GINSBURG: And they know that.

MR. ROLLINS: They know that. But to the extent that the benchmark is the average premium for basic coverage, you're always going to have some companies that are below that average.

MS. MARJORIE GINSBURG: Okay.

MR. ROLLINS: There have been cases where there may only be one or two benchmark plans in a region in a given year. That's fairly rare, and I think this year most regions have, I think, four or five plans, like you said in California.

MS. MARJORIE GINSBURG: Okay. So I had a question on page 14 of the report, and I guess it was related to that. It says that the price goes from $17 to $72 for basic coverage. So this is not -- I mean, doesn't that seem weird? That's not a very technical word.

MR. ROLLINS: I feel like you're asking me an awkward question.

DR. PAUL GINSBURG: Okay.

MR. ROLLINS: There is certainly a range of premiums in the PDP market, both in terms of the total premium and then one thing we talk about in the paper is when you look at the enhanced plans, you know, part of their premium is here's what basic coverage costs and part of their premium is here's what supplemental coverage costs, and those two dollar amounts there's a lot of variation there as well.

MS. MARJORIE GINSBURG: Yeah. Thank you. Based on our discussion we had previously about LIS, I got the impression that it was in the best interest of these sponsoring groups to price a plan that would get them in the LIS category because, you know, that's a given, particularly with auto-enrollment, that they are guaranteed. But clearly that is not true. So obviously there are many companies that say, fine, I'll price our basic so high that there's no way we're going to make the cut. You know, it doesn't matter.

MR. ROLLINS: Well, I think it's very much true that for the large national insurers, by and large all of them are interested in serving LIS beneficiaries, and in most cases their basic plan is a benchmark plan. To the

extent there's a disconnect in some of the smaller, regional PDPs and insurers -- like I said, a lot of these are Blue Cross plans -- they may not be as interested. But there is definitely a segment of insurers out there that have historically been very interested in serving the LIS market.

MS. MARJORIE GINSBURG: My last question. There wasn't a reference, I don't think, in this report about Plan Finder, and the use of Plan Finder for both LIS and non-LIS, as a way of actually making sure you've got a plan that meets your particular needs. I don't know whether you all have had any chance to do any research on who is using Plan Finder, how well it works. I know Medicare has been working very hard to improve it, continually. I use it a lot for clients, a lot, including LIS clients, and it makes a big difference. I discover one drug is not covered, even moving clients off of a benchmark plan to a higher-paying plan because they still will benefit more because the coverage is better.

So my question. Has there been much research on our end on Plan Finder, and who uses it? How successful is it? Is this something that can or should be promoted for

all beneficiaries who are in the market for a PDP?

MR. ROLLINS: So I don't think we've done a lot of work specifically on Plan Finder, but we have consistently been supportive of beneficiaries having tools that give them the information to help them pick a plan that best meets their needs. We haven't done a lot of work ourselves, but we have consistently viewed a well-functioning Plan Finder is a very good thing to have.

MS. MARJORIE GINSBURG: Okay. Great. Great report. Thank you.

MS. KELLEY: Brian.

DR. DeBUSK: First of all, I really, really enjoyed the chapter. It was a beautiful blend of strategy and analytics to back up the strategy.

I have two questions. The first one -- and this may be a little premature, but in the previous session we talked about DIR and allocation of DIR. Based on what I read before, is it reasonable, or is it possible for a plan sponsor to receive a lump sum of DIR and direct a disproportionate amount of that DIR toward its low-cost enhanced plan specifically to reduce premiums? Do they have that much latitude? I think the text said there were

several allowable approaches for DIR. Would one of those allowable approaches be a disproportionate redirection of DIR toward the low-cost enhanced plan?

MR. ROLLINS: I don't think we know enough at this point, certainly not enough for me to give a firm answer. If Rachel or Shinobu want to add to that, they are free to, but I think it's too early to sort of definitively say that.

One thing we did touch on in the paper was that if you look at the bids these different types of PDPs submit, they are assuming larger DIR payments for sort of these low-premium enhanced plans than they are for the other types of PDPs.

DR. DeBUSK: So we don't know if they're earning those DIR or they're just moving the money that direction.

MR. ROLLINS: I guess if you want to push it to that level, yes. We don't know exactly. There's a limit to how much we can understand sort of the what the negotiations look like and how the money is flowing.

DR. DeBUSK: And my second question. What's your sense for how much the 2023 revised OOPC model is going to alleviate some of this? Is the fix underway a little bit

or are there still going to be some -- what's your sense on that?

MR. ROLLINS: First, I would be remiss to say -- you should call it the "oopsy model" because it's one of the better acronyms in health care. That's what all the actuaries call it.

DR. DeBUSK: I stand corrected. Thank you.

MR. ROLLINS: Bruce will as well. The OOPC model [break in audio]. There is no way to construct a model where there is not some type of data lag in there, and right now the lag for the new model is going to be two years, but it's probably not going to get much better than that, given the timeline of when the data is available, when they have to make the model available to the plans, to prepare their bid, that kind of thing.

So there will still be some leeway for plans to sort of cover older drugs on the formularies and get credit. Hopefully with the new model their ability to do that will be somewhat constrained.

DR. DeBUSK: Your chapter alluded to anticipating to the behavioral response of the beneficiary. I mean, I was fascinated by that. I didn't know we could do that,

but I thought that was pretty promising too. Can you speak to that?

MR. ROLLINS: So one of the criticisms of the existing model has been that, you know, it's evaluating a particular drug, and whether it's on a plan's formulary or it's not. And I think sort then more of the real world, if you are taking Drug A and you are in a plan that doesn't cover Drug A on its formulary, one of your options would be to just keeping Drug A and pay for it entirely out-of-pocket, but one option might be, you know, maybe I don't take Drug A but this plan covers Drug B, which also works reasonably well for whatever condition I'm getting treated. I'll switch to Drug B.

Right now the model historically just assumes that if I'm taking a drug and it's not on the formulary, I just pay for it out-of-pocket. I think most people would say that's not very realistic, but operationalizing that in the new model is kind of tough to do, and I think that's what CMS has been sort of exploring, to see if they can sort of incorporate that kind of behavioral response.

DR. DeBUSK: Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: So I have a question that I think is somewhat similar to Marge's question. It's on Slide 5, or it's also Table 3 of the reading materials.

Basically, what I wanted to understand is, so we have the basic PDP premium and then we have the low premium enhanced PDP that has a lower premium. Then in the reading materials we also had broken out, in the table, the premium that goes with the basic coverage and the premium that goes with the enhanced.

And so what was I was curious to understand here is by regulation and by statute there is actuarial value of the basic coverage has to be equivalent across all of these. And so does that mean, essentially, that it's not that they're changing any dynamic of the cost sharing -- those may be happening but they're not intrinsically related to what we're describing here on this chart. It's simply that they're just choosing to set the premium lower?

MR. ROLLINS: Do you mean they're offering the same thing as other companies or just willing to accept less revenue for it?

DR. NAVATHE: It's not even other companies. It's just across their plans. So the basic portion of what

they charge for the basic plan, they're just choosing to charge a negative premium for that, in some cases.

MR. ROLLINS: Well, the negative premium is a bit of a special case, as we noted in the paper. To some extent you see it more with newer plans, where they have more latitude to make optimistic assumptions in their bids about who they think is going to enroll. In an older plan, eventually they have to tie their bid to their actual experience, and it's hard to justify a negative premium as your plan gets older.

But the bids for the plans themselves and the premiums are going to vary, depending on, for example, how broad or narrow their formularies are. I mean, they all have to comply with the CMS requirements for sort of minimum formulary requirements, but that's sort of, you know, kind of a base requirement and you can have a broader or narrow formulary working within that requirement.

Your cost sharing rules are also going to matter. As we noted, the low-premium plans, they do more than the other types of plans to get you to take a preferred drug and to use a preferred pharmacy, and those are going to help keep your costs down. They are going to probably help

you receive more DIR payments as well.

So there's a bunch of things going on that get reflected in sort of the premium in the bid.

DR. NAVATHE: So I guess the question that I'm trying to get at, another way of asking it is, from our assessment of what's going on in this market, is it that the differences between the basic coverage portion of a low enhance plan versus a basic PDP, are the differences in the premium there primarily driven by the structure of the benefit-designed formulary, sort of the structural pieces, or is more, quote/unquote, "idiosyncratic" in terms of how they're bidding to structure the premiums in the way they can to create this market segmentation?

MR. ROLLINS: I think it's hard to untangle that and say it's just one thing. It's a bunch of things together. To some extent you're segmenting the types of enrollees you think you're going to get. If you think you're going to get healthier enrollees, you're designed to attract lower-cost enrollees, you're going to have lower premiums. But there are also plan features as well, like we discussed.

So it's not just any sort of one thing. It's a

combination of factors.

DR. NAVATHE: Okay. Thank you.

MS. KELLEY: Pat.

MS. WANG: Thank you. This is an interesting Round 1. Can you clarify, is actuarial equivalence measured by sort of the gross price of the benefit structure inclusive of cost sharing, whatever the source of the cost sharing might be, or is it net of cost sharing?

MR. ROLLINS: Bruce is going to jump in here because he will know the specific requirements better than I do. The actuarial requirements, it's not just one tests. There's several different boxes they need to check in terms of what their alternative package of benefits has compared to basic coverage.

MS. WANG: Okay. But conceptually, where does cost sharing fit into a determination of actuarial equivalence?

MR. ROLLINS: Bruce will correct me. Cost sharing is one of the actuarial equivalent tests they need to meet. For example, if a beneficiary has reached the initial coverage in the benefit, in the Part D benefit phase, if they're not paying more under your alternative

benefit design than they would for standard coverage, for example.

MS. WANG: Okay.

MR. PYENSON: So, for example, it comes up with co-insurance, if the defined standard plan is co-insurance, and if you have co-pays and the co-pays have limits, the actuarial equivalence within the coverage zone has to tie back to the defined plan.

DR. CHERNEW: This may be helpful. I think -- and Eric will correct me -- they have a sort of standard set of that sort of benefit set of people, and then run them through different plans, and actuarial equivalence would basically mean that the out-of-pocket share in the plan you're proposing is essentially what the out-of-pocket share would be in the standard plan for this set of common people.

Now when you enroll different types of people it might not kind of match that way, but it essentially a way of aggregating the different dimensions of cost sharing to make sure the dimensions you're proposing loosely match the dimensions that the standard was.

How did I do, Eric?

MR. ROLLINS: I agree with that. On average, they're going to be the same. For an individual beneficiary it could be higher or lower.

DR. CHERNEW: If you're enrolling different people, it could be lower. They have the same problem on aspects of the exchange, is they pick a group of people, they run those people through different plan structures, and they try and figure out what the out-of-pocket would be. And that's a hard thing to do technically, but conceptually that's what they're trying to do.

MS. WANG: Thank you. That's helpful. So I don't know if this is the right -- so, you know, I'm focused on the fact that there are certain plans that become the LIS benchmark. Are those plan formularies tracking the LIS Part D benefit, like one tier, or are they also distributed across five tiers and then they somehow become the LIS benchmark? That's sort of related to the next question I had, was whether or not there are significant actual formulary differences among these three types of plans that you examined. And it's leading to the final question that I had.

MR. ROLLINS: Okay. Is the first question more in

terms of like how the benchmark gets calculated?

MS. WANG: Yeah, I guess so. My ultimate question is, you know, in this pooled approach, which I am thinking of as like the community-rated Part D PDP, stand-alone, one plan, kind of thing. So that's fine. Everybody gets blended together. There's a basic plan. There's a certain cost to it. How does that affect when MA plans, dual SNPs, are bidding against the LIS benchmark? Does that now become the LIS benchmark, and if so, is it an accurate representation of what the LIS benchmark should be? What would the interaction be there of your third model of everything all together, which includes LIS, non-LIS, five-tiered, whatever it might be. How does that translate into a dual SNP, an MA plan, sort of trying to match the LIS benchmark? Is there an LIS benchmark anymore?

MR. ROLLINS: So I think there's a couple of different ways you could do there. What we have now for the benchmark is we take the premium for basic coverage, for all Part D plans -- PDPs and MAPDs -- and we weight them by your LIS enrollments. So MAPDs account for an increasingly large share of that calculation. It's roughly

50-50 right now, PDP versus MAPD. So that's the way the benchmark is calculated now.

And you could use the same approach with a single risk pool. It would just be the PDP side of that calculation, if you will. Instead of having a larger number of pieces with individual PDPs, you would have fewer pieces, if you will, since each insurer would essentially be offering just one PDP. But the underlying mechanics could be the same.

MS. WANG: I guess the question is, will it be representative of this targeted population, which is from an MAPD perspective but dual SNP, which is now 50 percent of the market, I guess. Would it continue to be an accurate benchmark? In your example here, the premium would go down, and I just wonder whether that would be an appropriate thing to happen.

MR. ROLLINS: Well, I think we have -- and we discussed this more in September -- there a fair amount of circumstantial evidence that plans are not bidding as competitively as they could right now for their benchmark plans. And sort of the single risk pool would be kind of something of an indirect way to get at that, to sort of

hopefully give them stronger incentives to bid more competitively for their LIS population.

The benchmark is the average premium for basic coverage, and so whether or not you think that is appropriate I think, to some extent, is something of a judgment call on your part. But it is meant to be the average premium that is out in the market. And, you know, that's the way it's done now. You could still do it that way under a single risk pool, or as we discussed in September, you know, you could consider other ways of setting the benchmark.

I think one thing we touched on, at least in passing in September, is there's not a clear relationship between what the MAPD portion of the benchmark is versus the PDP portion. In some areas it's higher and in some areas it's lower. That can even change from year to year. So it's hard for me to give you a clear sense on like how those two sectors, if you will, compare to each other. It seems to vary a lot.

MS. WANG: Thanks.

MS. KELLEY: Larry.

DR. CASALINO: I think I'll withdraw.

MS. KELLEY: That is all I have for Round 1, unless anyone wants to jump in.

DR. CHERNEW: Which I hope they don't, because we have a bunch of people for Round 2. So if you do, I do want to make -- while you're pondering that -- I want to ask a sort of Round 1 question and also a sort of contextual point that I hope will help shape the discussion we're about to have.

There are two types of segmentation that are going on. One of them is between LIS beneficiaries and non-LIS beneficiaries, and there's a lot of concern about how that segmentation is playing out and what they're doing in there, and how that affects the benchmark.

The second is there's segmentation within the non-LIS beneficiaries, between those in, I'll call them the enhanced plan and I'll call it the unenhanced enhanced plan, which is not the language I'll try and use again.

I'm interested in knowing which of those types of segmentation you view as the bigger problem and how we should, as we go through this discussion, think about the concerns with segmentation, we might want to weight those two issues. How much of this is about problems with the

benchmark in the LIS world and how much of this is about segmenting the people in the non-LIS world between what I'll call generous but more expensive coverage and then less generous, less expensive coverage, and there's, of course, health status segmentation that's going on behind the scenes in that process as well.

That was a lot. That's sort of how I'm thinking about it. But if you have thoughts on that, that's great. If not, we're just going to open it up to Round 2.

MR. ROLLINS: No, that seems like a useful way to frame it.

DR. CHERNEW: And I think this, maybe not surprisingly, leads us to Stacie.

DR. DUSETZINA: I'll hardly talk tomorrow. I promise.

So thank you very much for this chapter. I think one of the things I struggled the most with is I don't know if I can answer the segmentation, whether it's a problem or not, because the one thing from the chapter that really stuck out to me was this issue of people picking a plan based on a low premium and then having the premium keep going up and being kind of stuck in it because they don't

actively choose a new plan, and then spinning out a new low-premium plan.

I think my answer as to whether this is a problem we want to deal with would be directly related to how often is that happening. Are we seeing that those higher premium enhanced plans are really just like, they started out low and just kept increasing and then they keep spinning off new options? You know, it's like a bait and switch for the beneficiary. You pick a plan based on a low premium and it just keeps going up.

MR. ROLLINS: So I can answer a little bit in terms of how often does this happen, which I think is one of the things you're asking. It's a little hard to get sort of a clear, you know, it's definitely X number of years or Y number of years, because -- and we talked about this some in the morning -- there's been a lot of consolidation going on in the market. So if you look back over the last 5 or 10 years, we've had a lot of companies buying other companies, and then because of meaningful differences they have to consolidate their plans and reboot their kind of PDP lineups anyway. So you have that going on.

You also have the regulatory change in 2019 to the meaningful difference standard. That made it much easier to offer two enhanced plans. And so we had companies that had not been offering two enhanced plans before that. Once this change was made, they started doing it. So there's a lot of stuff going on.

But to give some examples, probably the clearest example would be Humana, which hasn't been involved in a lot of mergers and acquisitions, and they've had three plans for many, many years. We talked about it in the paper. They kind of redid their lineup in 2020. Before that, the last time they did it was 2014. So that was 6 years. UnitedHealth has also not been involved in a lot of acquisitions, and I think the last time they reset their PDP lineup was 2017.

So, you know, to give you a very rough answer, I would say probably somewhere north of 5 years. My guess would be less than 10, though. But again, those are very rough numbers. But it doesn't seem to be something that happens like every year or two, if you will.

DR. CHERNEW: One thing on that point, though. That issue seems to be somewhat different than the issue of

segmentation. There's a problem that Marge raised, which I think is important, which is, we'll call it, broadly speaking, choice and efficiency, of which I think there's a fair bit of academic evidence that there's significant choice problems in the Part D market. That's a somewhat different issue it may relate to, to but a somewhat different issue than just the pure segmentation aspect of it.

MS. KELLEY: Was that it, Stacie? Okay. Brian is next.

DR. DeBUSK: Again, as I mentioned in Round 1, really, really enjoyed the report. I really think your report, too, underscored how so many of Medicare's challenges are structural. You know, it's not necessarily picking a number. It's just the way the system is designed that it leaves itself open to vulnerabilities.

Just to go straight to the options, I think Option 3, using a single risk pool, is the way to go, and I think it's for a number of reasons. First of all, I think it does restore the pricing model to the original intent of Part D, and how it was going to work. And I think it's also very complementary to our standing recommendations on

policies that encourage the better management of LIS beneficiaries, in general. So I think it is complementary to the work that's already been done.

And then I think, Eric, you probably said it best in the Round 1 session. I think you called it "indirect pressure" to manage LIS beneficiaries better. And I really like that term, "indirect pressure," and I hope it shows up again.

Michael, to your points about segmentation, to me it seems like the segmentation of the LIS and the non-LIS beneficiaries is the larger problem, because that basic plan allows them to inch closer and closer to the LIPSA and not leave any money on the table. I mean, they're basically maximizing their subsidy. So it seems like that's a fairly straightforward calculation to think about what would they have bid if they didn't have the luxury of being able to inch closer to the low-income premium subsidy amount.

And then on the churning, you know, the interesting thing about churning these beneficiaries is it seems like this is a problem that averages out over time, though. I mean, if I get into a plan early, when the

prices are low, and they increase over time, if I'm really price sensitive, I could even hop plans and get on the new low plan. So it seems like, again, it averages itself out over time, plus for the most price sensitive customers or beneficiaries, it might actually give them the opportunity to -- I hate to say "time the market" but basically, I would think that's what they could do.

But anyway, I really enjoyed the chapter, and I really appreciated the way that you blended strategy with analytics. Thanks.

MS. KELLEY: Bruce?

MR. PYENSON: I have the view that 150 years of experience in the insurance industry suggest we have to really be careful of selection and segmentation. And although it perhaps is not a huge amount of money at stake in Part D, which is, of course, pretty much smaller than MA, I think this is a principle that we can apply that would be useful here and in other environments.

So we have a voluntary market. People can fall out of it, choose not to buy Part D, so there's issues of selection that can lead to an assessment spiral. And that's kind of what happens, what Eric described, with the

very low-priced enhanced plans. Whenever that kind of thing happens, it always adds more cost to the whole system. That's just the mathematics of it.

So I think we do want to address that even if it's not a huge amount of money, I think there's a couple of things for future work that we need to look at in choosing options. One is what Pat was raising, how all this interacts with MAPD, which is half the market, and, of course, MAPD often subsidizes the premium down to zero. And so there are some other dynamics there that I think we need to consider, because I don't think it would be practical to sever PD from PDP and have two different bidding processes.

I was very intrigued by the third option of a common pool. My concern with that is that the market and the plans are, in fact, segmented. There's some of the big players that don't play in the LIS market, and how will they react? And are we going to end up in a worse place? I don't think so, but I think that gets into understanding dynamically the MAPD as well.

Let's see. I had a third point. Let me look at my notes.

My final point is that the actuaries you interviewed made points about instability in the market. I think Part D probably is too stable. You know, there's hardly any players, when you look at the plans. So I think some instability in the market would not be a bad thing, and perhaps the end game of the second option of letting the LIS enroll in the low-premium enhanced plans, maybe the end game of that would look a lot like the third option, the common pool.

But it might not be a bad thing to do that because it would create more instability in the market and more pressure on people, more opportunity to move around and put competitive pressure.

But this is really terrific work. Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thank you for this excellent work. I really appreciate how, from the past sessions that we've had on this, that we've kind of zoomed out a little bit to take a look at this from an overall segmentation but also, to some extent, how the market is functioning. I think that's very healthy, so I'm happy that we're doing that.

I want to touch on Mike's questions for a second,

because he said, you know, are we worried more about the LIS or are we worried about the non-LIS. And kind of have a two-part answer to that. One part is I think we need more details before we can actually make an assessment of that, but I think we're worried about both of them but we're worried about them for different reasons.

I think that LIS versus non-LIS piece, we are worried more about the efficiency of the program, and Brian alluded to this. Basically, are we essentially over-subsidizing relative to what we could, based on the value that the Part D coverage is providing for the LIS beneficiaries. And I think that's an efficiency question.

For the non-LIS piece of it, between the two enhanced parts, I think actually it's trickier, because I think we're living in a world there where we actually want to maintain stability of the market in the context of potential adverse selection. So the segmentation actually may be creating stability in the market. So I think we do worry about that a lot as we go forward, and we should be careful. And without some more details on how the networks and formularies and designs look different for basic PDPs that are meeting benchmark plan status versus the basic

option of the first enhanced plan, for example, it's hard to actually understand the "equity effects" or things we might worry about on the LIS question, to some extent, LIS versus non-LIS question.

And I think it's fundamentally important to realize that if, for example, we go to some sort of universal rating system, which is the option of putting everybody into the same plan, effectively pricing that with riders, we may end up with a large portion, or some substantial portion of beneficiaries who find coverage to be too expensive and opt out of the voluntary Part D market. And then we potentially create a market failure, where a market failure didn't necessarily exist, because of how we're regulatorily addressing that. So I think we should be very, very mindful of this as we go forward, because while segmentation sometimes sounds bad, in an insurance market where you have these selection issues, that Bruce and I think some of the other actuaries who were interviewed talk about, it can actually allow for the market to actually function.

So with that, that was kind of my comments. I agree with Stacie that the one piece that seems more or

less to me kind of unequivocally bad is this notion that there's a leveraging of the inner shove that exists in insurance marketplace choices, and it's just everywhere -- retirement plan -- it goes everywhere. And if that's being leveraged to basically enroll people and charge higher prices, over time, higher premiums, over time, that's unequivocally bad, and I think that's something that we should definitely think about going forward.

In terms of the plan options, I think the idea that we understand that there's actually different characteristics of beneficiaries and different plan types and use to that to then assess the value of the plan and what the sort of significant differences, minimal differences that exist between a plan, that seems to me like an obvious thing that's a no-regrets move that we would want to do.

As you probably inferred from my first comments, the idea of lumping everybody into the same plan, and then adding riders, seems to me to be a very potential destabilizing path to go forward, and I think I would really worry about that.

An alternative to think about is if we want to

get to this point where a basic PDP plan as a basic portion of an enhanced plan are effectively priced the same or the premium for that is the same, would be to explore an option where we just require that to be the case. And it would be different than putting everybody into the same insurance pool.

We would allow the plans to actually exist differently, because the supplemental portion of the coverage could still create partition, and it would still allow PDPs the flexibility to say price the plan in a way that they don't want to participate in LIS market, or give them the flexibility so that they do want to participate in the LIS market. But we could create a consistency such that the basic portion of the benefit, regardless of whether it's basic, enhanced 1, or enhanced 2, has to have the same premium assigned to it. That would seem to me a way to get at, I think, what some of the concerns seem to be here, without creating this destabilization in terms of how the insurance market itself is working.

So I'll stop there. But thank you. This is really fantastic work.

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Yes, I agree that Eric has really prepared us very well for this discussion, and it's been a very valuable discussion so far.

Now I think that the most important consideration is that we don't want the benchmark for the LIS plans to be inflated by the market segmentation. And there's one more option that we might consider, and I don't know if we would wind up supporting it once we thought it through, is to completely separate the LIS and the non-LIS parts of the markets. And I presume the drafters of Part D wanted to keep them somewhat together to make sure that the LIS beneficiaries had access to good, mainstream plans.

You know, that's one thing we'd have to weigh, but I think it's kind of caused all types of contortions on the basis of worry about segmentation. To be seeing them as one risk pool and maybe just the, it's not worth it and maybe we should just have a completely separate way of saying the benchmark, what the plans get paid for LIS enrollments, and the addressing it.

I'm not too concerned about the segmentation within the non-LIS part. It's something we kind of live with in insurance markets. You know, maybe it would be

better if we didn't have to live with that, but it's probably not a disaster if people that expect to be lower users but also are more willing to put up with restrictions select themselves into the lower-premium version. Thanks.

MS. KELLEY: Jonathan.

DR. JAFFERY: Thanks. And like other Commissioners, this is a great chapter. Just amazing how you distill things down and it enabled me, personally, certainly, to understand some of the market dynamics here, which are clearly complicated.

What jumped out at me was where Stacie started, and Amol. I have a lot of concern about beneficiaries choosing plans based on a lot premium, and then over time having that change for them and not moving out. And certainly while they have these options too, we know that people don't. And it's clearly very difficult to understand the options for people. As our conversations go, this is a really complex system, and we know that the average person is going to struggle with that.

So I'm glad we're talking about this. It does sound like we've got some good options to explore but a fair bit of work to do. And I know one of the things that

you were asking for is what is some future work that we might think about for the next cycle.

I, like Brian and some others, was attracted to an approach that looked like the single risk pool. I'm not sure that's the way it's formulated yet as exactly the best option, but I guess I'd like to see more future work looking at models along those lines. You know, when I think about it from a beneficiary perspective, and shopping, the notion of the riders seems fairly intuitive and easy enough to make decisions about. And I understand there's concerns about adverse selection. I'm not prepared to say that's exactly the way to go.

But that's what I'd love to see some discussion, and I don't know if over the course of the year there's opportunity to think about focus group discussions with beneficiaries about some of these choices as well, because I know some of the things that have been raised in the chapter and your presentation, things like riders might not be utilized very much. And I was curious about that since it does seem like that's similar. It's analogous to the way that people show for other things frequently.

Anyway, thank you again for such a clear chapter

and I'm excited about some continued work going forward.

MS. KELLEY: Pat.

MS. WANG: Thank you. I echo everybody's compliments, Eric, on a great piece of work.

Just to take the bullets that you have on here, you know, changes to the meaningful difference requirement I actually think will help a lot with some of the issues that have been identified, you know, meeting the requirements by adding older drugs, et cetera. And so I think that's important to track.

Auto-enrolling LIS in low-cost enhanced PDP, you know, I just don't know whether that eventually is self-defeating, because LIS is a more expensive population. It just is. There's greater utilization of restricted, of preferred class drugs, et cetera. The structure of the benefit does not lend itself to management, as we have described. It's one tier. Brand is next to generic. There's not even an ability for a plan within an LIS benefit structure to point out this is a high-cost specialty drug. Prescribing physicians don't even know. They don't see anything and LIS plans are not allowed to display them that way. Cost sharing is zero to minimal.

It's a very different benefit design.

So the third thing, to treat PDP enrollees a single risk pool, is kind of interesting within the context of stand-alone Part D plans. Again, my supposition is that the premium will go up a bit, because of the presence of LIS inside, and go down a bit because of the presence of non-LIS, and I'm not sure, over time, kind of what that gets you.

I share some concern about sort of the availability of buy-ups, I mean, just in general. I don't think that that's a great thing for insurance if we think people are not shopping now and are confused by the benefits that their Part D plan is offering them. I think riders are potentially very confusing and subject to bad choices and bad effects.

The question that I raised before, though, is my biggest concern with the third proposal, because we can talk about the desirability of segmentation of LIS and non-LIS within Part D, but the fact is that in the MA world it is segmented. There are D-SNPs. They exclusively serve LIS members. The benefit design is completely different, as I just described. I think that there should be more

discussion of the need to give plans who are serving the LIS population to have more tools to manage. It's not like plans are not motivated to manage the benefit and are just sitting around being lazy. I mean, it's very hard. Single tier, zero cost sharing. Very high use of protected class drugs, which, as we just heard, have very little DIR associated with them.

So I'm really concerned about doing something on the PDP side that looks like bullet 3, and trying to mesh that with the fact that there are, for good reasons, a segmentation in the MAPD D-SNP world where, you know, some would believe that that's a good thing for LIS beneficiaries. They are segmented today.

So I think blending them on the PDP side without fully understanding the impact on the MAPD D-SNP side would be dangerous. So that's my big caution. Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. Eric, I want to start with your first question on the discussion slide, and Bruce started off with this as well -- is segmentation a problem? So I want to try to think about this conceptually, and I don't know if it's useful or not. But it does seem to me -

- it's a great chapter, but it does seem to me that it's very concerned with tactics and not with strategy. And that may be okay, and politically realistic.

But, you know, just starting for basics, if I understand properly, in any industry a producer of a service, or a seller, can always maximize his profit by segmenting the market, right. And in this case to some extent the sellers, the insurers or the PDP plans, segment the market, and in some extent, Medicare has segmented the market for them.

So if segmentation increases profit or revenues for the sellers then that means it costs more for Medicare, period, for Medicare and beneficiaries, right? And we don't really want things to cost more for Medicare than necessary. And Medicare doesn't have to allow segmentation. It doesn't have to, right, or doesn't have to create it. It doesn't have to allow it. So if Medicare is creating and allowing segmentation, as it does in the PDP market, then there have to be benefits of segmentation that make the increased costs to Medicare and to beneficiaries worthwhile.

So what exactly are the benefits of segmentation?

And then from there I would go to, if there are indeed benefits to segmentation to make the extra cost to Medicare worthwhile, then are there ways that we can still get those benefits without the added dollar costs and maybe some other costs of the segmentation that's going on.

This is not a subject I know much about. I may be thinking about this too conceptually. But it does seem to me that an organization of the chapter along those lines, segmentation costs more, is to say are we getting benefit that makes that cost worthwhile. If not, do we just eliminate segmentation, which is unlikely, or do we try -- and this is what people have mostly been talking about implicitly, I think, is how do we try to jigger the segmentation so we get as much benefit as we can with as little cost.

But there doesn't have to be segmentation, and I think it's worth at least starting with that realization.

MS. KELLEY: Paul, did you want to get in?

DR. PAUL GINSBURG: Some of the things Pat said made me more interested in this notion of separating the two markets. You know, she reminded me about the fact that with virtually zero cost sharing and with a lot of their

conditions in protected classes, plans need other tools to manage this population effectively. And, you know, really that's what's happened over many, many years in Medicaid managed care, again, you know, without must cost sharing to use to motivate enrollees. You know, different approaches have been developed, and we're probably better off for having somewhat distinct managed care models for Medicaid population than forcing everyone into the same plans. So I'm thinking even more about separating the two, the LIS versus the non-LIS parts of the market.

MS. KELLEY: Betty, did you want to go ahead?

DR. RAMBUR: Thank you. I just will comment briefly. I thought this was a fascinating chapter and a fascinating conversation, and I appreciate this. You talk about work going forward, I'll say that my initial impression on reading this was perhaps like Jonathan and I think Brian, perhaps others, was the single risk pool. That just seemed to be so much more simple to me, and therefore more elegant. But as this conversation has gone on, the issues of riders or whatever, it seems very complicated.

And so I guess what I would value is additional

explication of the pros and cons of these different options, because right now I'd have to say I wouldn't even be sure what I would conclude. But it's a great job, and I'm glad we're looking at it. Thanks.

DR. CASALINO: If I may, too, I mean, Eric, the last three bullets, they're on the same plan as three bullets, but the first two, you know, in my reading, would be ways to try to make segmentation work better, and the third one would be ways to get rid of segmentation, at least in that market. So again, that distinction might be useful.

DR. JAFFERY: ON this point.

MS. KELLEY: Sure.

DR. JAFFERY: Yeah. If Larry went conceptual, I am going to go even more conceptual.

I think there are two concepts broadly on the table. One is the financial efficiency of this program, and the other is an issue of program design. And it's whether we're maximizing distributive justice or whether we're maximizing tools, which may be another form of justice, for an adversely selected population, a la Pat's point.

And the reason I'm going hyper-conceptual on this is that until we kind of step back and say, okay, what is it we're trying to maximize in both of these, then I think it's going to be hard to land on the approach to optimization.

Paul's important point about segmentation, you know, leads one to a sort of financial model that appeals to consolidation so that the risk is distributed broadly. On the other hand, you know, depending on which features you're trying to maximize, either with intent for social justice and distributive justice and what your belief is on how that's best effected -- peanut butter spread or focused directed for adversely selected -- or, in fact, beneficiary choice that may be less sensitive to either of those two, I'm really struggling to land on, okay, how would I solve this problem without a clear philosophical construct from which to frame. Thanks.

DR. CHERNEW: Thanks, Jon. That is actually very useful. Bruce, I think, wants to get in. Bruce, I think I have you as last. Dana?

MS. KELLEY: Yes.

MR. PYENSON: It just struck me that a lot of the

issues we're talking about have analogs in the relationship between Medigap and Medicare Parts A and B. And there's decades of experience there.

So not to enlarge the scope, but the issues, you know, adverse selection and induced utilization, all sorts of other things, looking at analogs from Medigap might be helpful.

DR. CHERNEW: And as an aside, in Medigap they very much standardized the plans and the benefits and exactly what was going on, and they made huge strides when they did that. I think there's other things going on but I think that's basically right.

And to your point, Jon, as we wrap this up, one of the challenges with segmentation, to your distributive justice point, is it allows people who are relatively healthy or relatively willing to accept restrictions to have a plan and a premium that meets what they want, given their health status and their preferences. And when we pool everybody together, we make it harder for those people, but we help a bunch of other people, because we are pooling them together. That is, I think, a much, much larger lift discussion than how we deal with the inertia in

choice, which is an issue in this, or how we deal with sort of segmentation -- I don't want to use the word "gaming," because I don't mean gaming, but strategic behavior in terms of the bidding of plans, particularly around what we talked about earlier in the fall, on the Part B benchmarks in the system we've done there.

So there's a lot floating around here. What I hear is -- Amol is going to synthesize this better in a second -- I hear broad interest in this topic. Let me change that. I hear broad interest in these topics but mild uncertainty about which of these topics to prioritize, in which order, and how to weave them together.

And so I'm going to leave it there. Luckily, Amol, you're going to get the last word.

DR. NAVATHE: Thanks, Jon, for bringing this up. I think it's really helpful. And I wanted to try to clarify and see if people agree with how we think about this notion of distributive justice versus LIS, in the framework of how we're thinking about this.

If we're thinking about this in the context of distributive justice, it doesn't, in my reading and my view of this, that's not an issue between the LIS and non-LIS

portion of this, because of the way that the LIS, the needs are subsidized into this.

So if we are talking about this in the context of distributive justice, we're worried, within the non-LIS population, not the LIS population, that the LIS population piece of this is a program efficiency point. So I think it's really important, because I think when we start talking about distributive justice in the context of LIS it takes us down a totally different path, which is now what we're talking about here.

DR. CHERNEW: I agree. And so, in fact, back to my sort of, there's an LIS, non-LIS question, is important and raises a range of issues, and then there's a segmentation within the non-LIS, which, again, there are a lot of aspects of that segmentation can reflect inefficiencies, some choice problems, some other things. We might not like the lack of pooling between sicker people and healthier people, and there are a lot of issues there. But they're different than the LIS/non-LIS issues.

And so I think we're going to wrap this up and take a five-minute break, but I think, so you all know, if you want to send emails or whatever later, what I heard,

and later I will hear what Jim heard, but what I heard is there's a lot going on in this market that's useful, and a lot of complexities between this. I didn't even mention the MA interactions that Pat praised, that I think are also very important.

We are just going to need to put our heads together over time to figure out how to do this in a way that is not so boiling the ocean that we struggle with all of these problems. And I think that's just where the clear issue is.

So to Eric, I will say, what a bunch of us were talking about, there is universal praise for this chapter, even with you not being around. And I think there's a ton of interest, and I think in the writing of this you nailed exactly the dynamics. And we just have so much going on that we have to figure out where to go.

So that's my summary of this. Let's take a five-minute break. Larry?

DR. CASALINO: Yeah, just very briefly. You know, I just want to emphasize, segmentation is not synonymous with gaming or any kind of behavior that we would consider shady. I think the more segmentation there

is, the more opportunity it leaves for gaming, probably. But segmentation itself can just mean you give people who have more money more of what they want, and you give people who have less money what they can afford, and you go right up the chain. There's nothing illegitimate about that. Whether that should be a Medicare policy or not, and Medicare should pay more for that and others, is a question that can be addressed. And Jonathan and Amol talked about some of the issues of that.

But segmentation itself should not be a dirty word, right?

DR. CHERNEW: That's right. And, in fact, more broadly, I think Part D was founded on a principle of giving people choice so they can match the premiums to what they want. That was an underpinning of Part D. Marge.

MS. MARJORIE GINSBURG: A last comment. I think Paul was the one that originally suggested the idea that perhaps we take the LIS folks out of this pool entirely and create their own thing. I think several other people made reference to it.

I just wanted to go on record as saying I think that's a great idea. I think these are such entirely

different populations. I see no reason to continue to marry the PDPs as if everyone was created equal. They're not. Everything is different about LIS, and I hope we can carry that a little bit further in terms of analyzing that as a possibility.

DR. CHERNEW: And now Amol has the last word. Not Amol. I'm sorry. Marge. Amol was going to have the last word. It ended up being Marge. Actually me.

So again, thank you, Eric. Thank you all. We're going to take a five-minute break and we're going to come back to talk about a topic which I know you guys are super interested in, which is social determinants of health, and it's one that we are continuing to work towards.

So let's take a break. We will be back to talk about that in five.

[Recess.]

DR. CHERNEW: Welcome back. As I think all of you know from the retreat and onward, this issue of social determinants of health, what and how Medicare/MedPAC can engage in it, how it dovetails with a bunch of other things, remains a priority for us. It is a complicated area. It's one that I know all of you care a lot about, so

we're going to turn it over to Ledia and Geoff to take us through this material.

MS. TABOR: Good afternoon. The audience can download a PDF version of these slides in the handout section of the control panel on the right-hand side of the screen.

The Commission recognizes the importance of social determinants of health for health outcomes. Commissioners have recently raised the question of how Medicare can better address social determinants of health or social risk, especially as the Commission continues its work to drive value-based payment in Medicare.

Today's discussion will examine how some Medicare policies can address social determinants of health.

First, I'll spend some time discussing some background on the topic, including the connection of social risk and health outcomes.

Then Geoff will summarize our work with L&M Policy Research to conduct a literature review and interviews with health care organizations around interventions to address social determinants of health.

Next, I'll review MedPAC's work to date

addressing social risk and other ways the Commission can continue to support improving social determinants of health. After the presentation, the Commissioners will have an opportunity to provide feedback on the presentation.

First, to define some of the terms we use in this presentation. There are different definitions available, but we have flagged some as examples for context.

Social determinants of health are centrally conditions in the environments in which people are born and live that affect a wide range of health, function, and quality-of-life outcomes. Examples of social determinants include safe housing, food security, and transportation options.

Social risk factors are constructs that capture how conditions influence health-related outcomes. Examples of measures of social risk include dual eligibility for Medicare and Medicaid, race and ethnicity, and neighborhood deprivation indices.

The past decade has seen a growing recognition of the importance of social determinants of health on health outcomes.

This widespread recognition of health disparities has prompted many organizations in the public and private sectors to prioritize social determinants of health as a key component of health care quality improvement. For example, many health systems are making sizable investments in addressing social determinants of health, in particular housing-focused interventions.

Also, CMS has prioritized advancing health equity across all its programs. For example, improving health equity is being incorporated into models tested at the Centers for Medicare and Medicaid Innovation, and CMS released a number of requests for information on how to close health equity gaps in Medicare quality reporting programs.

The uneven COVID-19 outcomes have further elevated the role social determinants of health play in health disparities. Black and Hispanic Medicare beneficiaries have been disproportionately impacted by the disease.

When thinking about Medicare policies to address social determinants of health, it is important to think about the financial incentives providers have to address

social risk.

There is little financial incentive under fee-for-service for providers to address the social needs of their patient populations. Such incentives often increase practice costs without commensurate increases in revenue.

Capitated payments can provide incentives for plans and providers to consider patient health more holistically, which can mean attending to social needs. Some MA plans can now innovate on supplemental benefits, including some non-medical benefits that can target social determinants of health -- for example, meal services, produce, transportation -- but it is unclear how many members are using these services and their effectiveness.

ACOs allow providers to earn shared savings. Keeping costs under a target may justify investments and partnerships in support of social determinants of health interventions.

Geoff?

MR. GERHARDT: At a previous meeting, Commissioners asked us to research interventions that address social determinants of health and whether such initiatives are associated with improvements in health

outcomes and reductions in health care costs.

MedPAC subsequently contracted with L&M Policy Research to conduct a literature review and stakeholder interviews. Five broad themes emerged from this work.

First, many organizations are working to address SDOH, but objective evaluations of their effectiveness are limited and findings are often mixed.

Second, we learned that SDOH initiatives are usually aimed at populations that often include but are not exclusive to Medicare beneficiaries.

Third, participation in value-based payment arrangements, such as ACOs, can help motivate efforts to address SDOH.

Fourth, there is a great deal of variation among the approaches and specific interventions that have been used to address SDOH.

And, finally, most health care organizations are not operating SDOH -- SHOD initiatives by themselves. They usually collaborate with community based-organizations such as food banks or public housing agencies.

Looking more closely at the literature review, there were 33 studies that met our criteria for inclusion.

These studies examined inventions that included Medicare beneficiaries and older Americans, but usually were not exclusive to Medicare beneficiaries.

The most common types of interventions in the studies involved programs designed to address coordination of care (which includes connecting at-risk patients to medical and social service organizations), food insecurity and nutrition, and housing needs.

Twenty-four of the studies indicated that efforts to address SDOH improved at least one measure. Most of the improvements were for clinical outcome measures, such as blood pressure control or changes in utilization like a reduction in hospital readmissions.

Relatively few studies examined whether an intervention was associated with significant changes in health care spending, and findings were mixed among the studies that did.

In addition to the literature review, we conducted structured interviews with ten health care organizations to get a sense of how they are working to address SDOH.

All of the organizations we interviewed have

programs that are focused on improving food security, and most also have initiatives that address transportation and housing needs.

While each organization is taking a different approach to addressing those needs, all of them depend to some degree or another on partnerships with community-based organizations, or CBOs. Once patients with SDOH needs are identified, most of the organizations we interviewed refer at-risk patients to a CBO for assistance, while some organizations take a more direct role in collaboration with CBOs.

When asked why they chose to address SDOH, the interviewees pointed to a variety of reasons, including mission-driven values, specific needs in the communities where they operate, and participation in value-based payment arrangements, such as shared savings programs.

Funding for their initiatives comes from a variety of sources. In some cases, funding is primarily from demonstration programs or income from philanthropic donations. Other organizations use operational revenue, which for MA plans can include rebates from Medicare Advantage. Payments from value-based payment programs were

also cited as an important funding source.

I will now turn things back to Ledia.

MS. TABOR: MedPAC has traditionally focused on modifying payment systems to incentivize health care providers and payers to deliver high-quality care in the most efficient manner.

While strong incentives for achieving value-based care objectives are critical, it is also important to apply such incentives fairly -- that is, to recognize when these incentives place certain providers at a relative advantage or disadvantage.

I'll now highlight some of the Commission's work to address these disadvantages.

A quality payment program should account for differences in the providers' patient populations to counter any disadvantages they could face in achieving good outcomes.

If providers with populations at high social risk are disadvantaged in achieving good performance, then a quality payment program would stratify providers into peer groups based on the social risk of their patient populations to counter those disadvantages. A payment

adjustment would be made to each provider based on its performance relative to its peers.

Over the past several years, the Commission has recommended redesigned quality incentive payment programs for hospitals, Medicare Advantage plans, and skilled nursing facilities that incorporate peer grouping.

The Commission is concerned that the care of low-income beneficiaries or patients with public insurance being concentrated among certain providers may create an undue financial strain on these providers. This may result in diminished access or quality of care for beneficiaries who live in areas served by these providers.

For these reasons, the Commission started a body of work this analytic cycle examining safety-net providers. The work includes exploring how they should be defined and how the Medicare program can best support their critical missions.

In the past we have highlighted some disparities in care when we have identified them in our payment adequacy analyses. For example, in the March physician chapter, we report differences in beneficiary experiences accessing care by different subgroups -- for example, by

race and ethnicity and dual eligibility.

Moving forward, the Commission will more deliberately incorporate analysis by social risk factors, in particular income and race/ethnicity, into our payment adequacy and other analyses. For example, we plan to calculate and report provider-level disparities in hospital quality measures.

These types of analyses may identify needed policy changes that the Commission can pursue to improve health disparities.

There are other policies that the Medicare program can leverage to address health disparities.

Medicare could improve data collection of beneficiary social risk information. A prerequisite to measuring and reporting quality for beneficiaries with social risk factors is knowing beneficiaries' social needs. Beneficiary social risk information is not routinely or systematically collected across the health care system.

In our quality payment and safety net provider discussions, we have acknowledged the need for more comprehensive proxies for identifying beneficiary social risk and also the limitations within claims data.

Medicare can also stratify quality measure results by social risk and publicly report them.

Stratified quality measure results that are publicly reported could allow policymakers and providers to measure and track outcomes for beneficiaries with social risk factors over time and reduce disparities and incentivize improvement. Progress has been made on stratified reporting of measures, but more can be done. For example, CMS has recently expressed intentions to publicly report hospital-level quality measures stratified by dual eligibility, race and ethnicity, and disability at some time in the future.

In summary, desired health outcomes can be adversely affected by social risk factors such as income, housing, and race/ethnicity.

MA plans and alternative payment models, like ACOs, have more flexibility and incentives to focus on improving outcomes for high-social risk populations, but it's unclear how incentives are implemented and their effectiveness.

MedPAC has been working to address social risk factors. We have redesigned quality programs and are

examining safety net providers payment with the aim to apply incentives fairly.

Moving forward, where available, the Commission will more deliberately incorporate analysis by social risk factors, in particular income and race/ethnicity, into our future payment adequacy and other analyses. The Commission is also interested in collecting better data on social risk and publicly reporting quality disparity data.

This leads us to your discussion of reactions to the approach and other ideas we can pursue.

I'll now turn it back to Mike and look forward to the discussion.

DR. CHERNEW: So, Geoff and Ledia, that was terrific.

We are about to start the queue, and if I have this right, the first person in the queue is going to be Jonathan. Dana? Okay. Jonathan, you're up.

DR. PERLIN: Great, thanks. Yeah, this is a fantastic chapter. I loved reading this. I am super excited about this topic. It has been near and dear to me for a long time. I'll get into some more things in Round 2, but my question is about -- you did the literature

review and the interviews, and you laid it out really nicely in the chapter and the presentation about what different organizations might be doing, at least a relatively small sample.

One of the things about addressing social determinants of health is that a lot of these things are very geography based -- right? -- affordable housing, food access, and things like that. And so I can tell you -- and I'm happy to give you some more detail offline -- about what we've done around the community, because we've done a very community-based approach in Dane County with all the health systems and the public school system and United Way and so forth to create sort of a bi-directional community-based organizations referral system, actually working with Epic as well. It just went live a couple weeks ago, so it's very exciting.

But I guess my question is: Were the interviews -- were you finding things that were pretty exclusively focused on what an individual provider system is doing? I know that they're partnering with the CBOs, but as opposed to collaborating across a community to really try and address that holistically.

MS. TABOR: I think it was mainly the latter that they were really working to partner with community-based organizations. We did have some health systems that were building some in-house infrastructure, like having a food bank within the hospital, but then -- so that it could get patients' immediate needs, but then also connect them to Meals or Wheels or other things out in the community.

DR. PERLIN: I got that from the -- I guess I wasn't clear. But that was still a single system doing -- you know, if there's three hospitals in town, they might each be doing that, but they're doing it on their own with -- in partnership with probably the same CBOs as opposed to all three systems or the community coming together broadly, the providers coming together to say we need to address X.

MS. TABOR: I would say, based, again, on the small sample that we spoke to, the Accountable Communities for Health, we spoke with two of the Accountable Communities for Health, which is a CMMI program, which is giving financial support to organizations within a region to both work on identifying and screening patient populations, but also connecting patients with CBOs. And I think that's done kind of outside of the health system.

MS. KELLEY: Lynn?

MS. BARR: Great chapter. Thank you so much for this work.

I have some questions about how to -- how are you evaluating income information on beneficiaries? I'm most actually interested in something that we can empirically start analyzing our population. I mean, you would expect that the lower the income, the higher the total cost to Medicare. So what are we doing to gather income information today?

MS. TABOR: So we are limited to what we have available in the Medicare claims data, so, for example, on the quality payment work, we used eligibility for both Medicare and Medicaid pool dual status, but with the safety net work, that team has been working on a broader measure of income that includes full duals, partial duals, and those that are LIS. So we've kind of found that's a broader, more comprehensive --

MS. BARR: So still missing like 80 percent, right?

MS. TABOR: We only have as much as --

MS. BARR: Yeah, I know. But it does become the

problem, because if we're going to identify these patients -- is there any possibility of getting the IRS to just give us information that says this patient is below 100 percent of the federal positive limit or 200? Has there ever been any discussions --

DR. MATHEWS: No.

[Laughter.]

MS. BARR: And I take that to say, "And there will be no discussions." I mean, because it would be incredibly valuable for us. For example, you mentioned that half the LIS eligible patients are not signed up for the program, right? But we don't know who they are because we don't have their income information, so if we had flags on people, we'd go, oh, okay, this is a special snowflake we should be considering.

I think the rest I'll have to save for Round 2. Thank you.

MS. KELLEY: David?

DR. GRABOWSKI: Great, thanks. First of all, this is fantastic work. Similar to other Commissioners, I'm very passionate about this issue given my research on the duals.

Jonathan pushed you a little bit on the stakeholder interviews. I wanted to ask you about the literature review and just kind of -- it seemed like it was all over the map there in terms of results. You said there was a variety of approaches and measure. Could you say more about just the quality of that work? What's the quality of the underlying studies? And how strong -- there's a tendency to want to count up, you know, ten studies found this, eight studies found that, the research is mixed. Are there better studies we could weight a little bit more?

MR. GERHARDT: I mean, our primary goal in looking at the studies was to try to find a relevant population as well as, you know, cases where they were making a genuine connection between addressing social needs and improving health. There was probably less attention paid to the specific methods or quality of, you know, the studies themselves, and I would say that they range from being highly rigorous and what you would expect in a good peer-reviewed journal down to, you know, more quantitative -- you know, cross-sectional data and things like that.

So I think it's really hard to characterize

across the board, you know, these 33 studies were all strong or they were all weak. I think they really ranged depending on the specific study and how it was done, and that's, you know -- but that was our starting point. That's what we had to work with.

MS. TABOR: I'd say our hypothesis kind of going in was that there probably is no magic bullet, and I think that you could probably walk away with that being confirmed.

DR. GRABOWSKI: That's fair, and maybe this isn't a follow-up question but just a quick point. We may want to add that in, something about the rigor of the studies, and any way that we can build that in, I think that would help sort of the takeaways from that part of the chapter. Thanks.

MS. KELLEY: Bruce?

MR. PYENSON: I've got a research question with a little different line. Social determinants of health are, of course, not a unique U.S. issue, but the U.S. tends to medicalize things. I'm wondering if there's any thoughts on looking at how other countries involve the medical system in the social determinants of health, if they do at

all, or if there's other mechanisms in other systems.

MS. TABOR: And what I've come across, you're right, I've read the same things that social determinants of health are not a unique U.S. problem. But as far as what other countries or systems are doing, we haven't looked into, but it's something we can explore. I don't have a strong answer for you.

MS. KELLEY: Wayne?

DR. RILEY: Yes, thank you, Ledia and Geoff, for an excellent chapter. Can you give us any insight to what our L&M consultants shared with you about community-based organizations? The reason why I ask, in the paper you elucidate that the ten organizations refer to CBOs in either a screen-in service or screen-in refer model. And like many of my Commissioners, we all sit on lots of nonprofit CBOs, and it just struck me. Is that the right chassis on which to build a mechanism to address health disparities? Because these CBOs are so underresourced. Every CBO that we're a member of that you know -- and many of you sit on all the CBOs around the country as well -- they're always, you know, scrapping by for resources.

So it's maybe a more philosophical question with

a comment, but any more insight you can give us on the CBOs?

MS. TABOR: So in the interviews that we participated in, this was not an unfamiliar comment to hear about that a lot of the work in implementing any interventions was really just spending time on the partnership and also understanding that the CBOs only have the resources that they have. That was kind of one of our takeaways from this work, was, you know, thinking about Medicare, there's only kind of so much the Medicare payment program can do because so much is relied on this kind of local infrastructure. So your point is a philosophical question that we heard consistently.

MR. GERHARDT: I would say one thing we heard almost universally was, to your point, the importance of funding these CBOs, however they get funded, whether it be with tax dollars or other resources that come to them; and because they are such an important component to actually doing these programs, that almost all these organizations worry about shortfalls in funding at the CBO side. That was one thing a lot of them stressed, was the fact that they need continued or more funding to be able to scale

these things up and continue to do what they're doing.

DR. RILEY: Yeah, and just quickly to follow that up, you know, like I said, it's more a philosophical, existential question. Is this the right way to address social determinants of health among Medicare beneficiaries, knowing that CBOs have limited capacity, strength, funding, et cetera, et cetera?

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: I'm curious. It seems like everything you read these days, somebody is doing a project, either foundations or even states, on health equity and health care equity. I know California is launching something, and so many foundations are.

Did any of your research reach those groups as well, even though they may not have any finished products yet but are exploring ways to deal with the health equity issue? And if not, is there a reason to reach out and find out what they're doing?

MS. TABOR: Do you mean like state Medicaid agencies or state departments of health or --

MS. MARJORIE GINSBURG: Yes.

MS. TABOR: In our ten interviews, we did speak

with one state Medicaid agency.

MS. MARJORIE GINSBURG: Okay.

MS. TABOR: And they provided some interesting insights about really how they're working with CBOs and trying to kind of build a community with all the local health systems and CBOs to kind of build an infrastructure. But if there are specific questions you have or --

MS. MARJORIE GINSBURG: Not so much specific questions, but have other organizations with a similar intent done some of the work that will help make our life a little easier and whether we can get information from them about approaches -- what they've learned, approaches they're taking. I don't think anybody is done with any of this work. I think they're just starting it. But I would hate to lose them as a source of information if it might be valuable to us.

MS. TABOR: Yeah, so like I said, we spoke with one state Medicaid agency that has been working to, you know, work on health disparities. There are many more. I think it's something we'll just continue to keep tracking.

MR. GERHARDT: Most everybody we've talked to said that their programs are a work in progress. You know,

we would need to come back to them in a couple of years to really see how things are going. So I think it's something we're just going to have to monitor.

MS. KELLEY: That's all we have for Round 1.

DR. CHERNEW: We're about to jump into Round 2, but, again, I want to make a contextual point before we jump in. I think there's a narrative that I often hear that suggests that if we address social determinants of health we will save money, and that narrative pushes you down a path to suggest that organizations taking, say, population risk or some other thing would want to invest in these programs because they will then ultimately save money.

I think the literature, by and large, doesn't support they'll save money, and I'll go on record as saying the motivation for addressing social determinants of health and health disparities is not to save money. Right? I don't think we should expect that they'll save money, and I don't think we should limit our attention in this detail to those that do save money.

That raises a broader question of how to finance this in a much more complicated way, and not expect that

there's some type of free lunch that will occur. And I think as we go through the lit review and we think about how we're looking at whether or not these programs work or don't work, we have to be particularly cognizant of the fiscal implications because they influence how we do funding.

My general view is in some of the payment mechanisms that we put in place, we should pay for things, and that actually means, just to be super-clear, we actually pay for things, like we pay more money to get things. And this is one of those areas where I think we have to pay attention, because I think -- I'll just channel Bruce. In a long line of other related things, disease management, wellness, et cetera, there has been a narrative that these things will save money and that we should only do them if they save money, prevention, primary care, a bunch of these. And I think some of them have helped benefits in ways that are actually worth paying for.

And so that's relevant to the lit review, and it's relevant to how we think about the financing and how much we would expect organizations to invest in them. If these organizations have a budget constraint in varying

ways, they're going to behave differently. So that's my perspective on at least how we begin to think through this, and that we should stay cognizant of that as we go forward.

So as is clear, I hope, to those at home -- and I know all of you know this -- we're at the beginning. This is an agenda-setting type of discussion. It's an enthusiasm type of discussion, and I happen to know how enthusiastic you are. But, anyway, so I'm looking forward to sort of comments on those types of directions.

That said, I think Round 2 is again going to start with Jonathan. Is that -- okay.

DR. JAFFERY: All right. Thanks. Again, this is a great discussion, and all the Round 1 comments from my fellow Commissioners have been amazing.

You know, having been in this space now for quite some time, it has been really interesting to see the evolution, talking to providers about social determinants of health for over a decade, and it has really gone from, you know, "What are you talking about?" to "That's not what we do," to "Yeah, we have to think about that. I have no idea what to do." And to where we are now, which is trying to do things, but as you learned from your interviews,

largely very early.

Thinking about how we're going to keep looking at this going forward, a couple things come to mind. In thinking about the literature, there's actually something -- I don't know if you've come across it -- that comes out of the Population Health Institute out of the University of Wisconsin that's called "whatworksforhealth.wisc.edu," and so it's actually a curated database that looks at evidence along the different social determinant areas, and you can search it based on the different factors -- you know, behaviors and clinical care and social determinants or social factors and physical environment. You can also look at evidence level so look at, you know, good evidence and maybe spotty evidence, by who has to implement the programs -- are they policymakers? Are they health care providers? Is it law enforcement, and so forth, as well as also looking at impact on disparities? So it might be worthwhile looking at.

I think, you know, some of the things we've talked about in terms of data collection and analysis and reports, super important. We can't improve what we don't measure, so starting to think about how we embed some of

these other things within our reporting in Medicare and then hopefully more broadly there's some momentum there. The one thing I would suggest is you talked about race and ethnicity and thinking about language as well, because that's something that people have been looking at.

And then, you know, this question about investing resources that Mike brought up and that Wayne and Marge have commented on in terms of CBOs being underresourced, this is clearly a huge issue. I mentioned the initiative we're working on. I didn't mention it before, but it's focused on trying to eliminate disparities for Black families in terms of birth outcomes. And so, you know, a lot of those things are not going to save money, although if we do prevent NICU stays from low birth weights, that's a big cost saver.

But one of the ways, in addition to what I talked about earlier, is to try and work with payers, Medicaid in particular but also some other payers, to reimburse for doulas as an example. I could go on and on about this project and would be happy to later, but I think that's the kind of thing that we want to explore and to some of the other comments.

But things going forward, this in particular strikes me as something that really is going to require some collaboration with states. You brought this up already. You talked to one state. But because of the sort of geography-based nature of this as well as some of these other payment issues and how do you invest in things locally, I think it would be really important to think about how do we weave this in for Medicare to think about how it works with states, maybe more so than a lot of other things we do.

So I'm really excited for the next cycle to think about this even more, and thanks again for the chapter.

MS. KELLEY: Bruce.

MR. PYENSON: Just a thought that we're at a point in this conversation that seems like the beginning of CMMI, and, you know, we've just had a critique of the experience of the first ten years of CMMI, and I'm wondering if there's -- if we can keep that in mind. Part of, I think, the overall recommendations seem that it would be better off if it were more focused. And I think perhaps some of the good outcome of this, which is what you're suggesting is to really focus on what can work or what --

rather than let's experiment with lots of things. So I just wanted to make that -- connect to that analog.

I do have a cautionary note on medicalizing things that the medical system is not going to do well, and we've kind of seen that with public health issues where it's fallen on the medical system to increasingly conduct what ought to be public health initiatives, and not that that's a terrible thing. Someone has to do it. But it's probably not that efficiently run through the health care system. So just a couple of cautionary notes there.

I think that the final view -- and I'd be interested in Jonathan's view -- that the community approach to that means everybody. It doesn't mean just the safety net hospitals. It means everybody in the community, the profitable hospitals --

PARTICIPANT: Ought to mean.

MR. PYENSON: Ought to mean, and so often the approach has been by a lot of folks, "This isn't my problem. I don't see those patients." Well, that concept has to change, I think. Is that how you're doing it in Wisconsin?

DR. JAFFERY: Yeah, and so essentially there's

what's called the "Dane County Health Council," which has been around for, I'd like to say, "since the 20th century," because I think it formed in 1999. But it came together to focus on how we manage people who are uninsured, and so having just that dynamic -- or avoiding that dynamic where it just all goes to one place or another, and then I've been sort of the UW health executive member of that for seven or eight years, and about four years ago we shifted our mission to think about social determinants and population health, and, you know, every hospital does its community health needs assessment as part of the ACA, but they're all separate and they're all on different cycles. And so we harmonized that, so we all do a joint one with public health, and actually some of the other -- there's a local staff model HMO that doesn't own a hospital, but they do it with us, too, and the local FQHC. So there's sort of that history of collaboration, and all these -- we also don't have lots of small practices. So it's all the big hospitals and the FQHC and some of these other groups, and it's notable that the groups all share one of our epic platforms and the FQHC has our platform of EMR. But it's absolutely sort of an all-in, all three hospitals in town,

basically. There's also a VA that's not part of it, but it's a little bit trickier.

MS. KELLEY: Lynn?

MS. BARR: Great chapter, and I'm really looking forward to this work progressing. So you mentioned in your presentation that, you know, the funding for this, one of the most available sources of funding is from ACOs and, you know, from value-based programs, and you mentioned the QPP as funding vehicles for these. Certainly in our safety net ACOs we do a lot of this work, and we do it for free, and it's just -- and, you know, things like transportation totally make a difference, you know, getting people refrigerators so they can have insulin, you know, that matters. So there's a lot of good work there.

But my concern is that those payment models actually disadvantage the safety net, and so this gives me an opportunity to talk about one of my biggest concerns right now, which is, as you know, the most expensive patients are the ones with socioeconomic determinants of health, right? And the providers that are the most expensive today possibly are the ones that are treating these patients, right? And so we talk in our ACOs about

inefficient providers. Are we really talking about inefficient providers equally, or are there inefficient providers and providers that are taking care of the safety net? And we lump together.

The reason this has become a tremendous concern is because the regional benchmarks penalize inefficient providers, and so in the REACH model, which was intended to reach the safety net, it has a 50 percent element of the regional benchmark in it which, in my cohort, is an instant 5 percent loss against the benchmark, right? So they would go into the program 5 percent lower than everyone else. And so as Bruce will tell you here, people are selecting providers to be in these models that are not higher than the benchmark, that are not more expensive.

So safety net providers are -- we get phone calls every day now right now because they're getting kicked out of the ACOs because they're more expensive than the benchmarks so they can't afford to have them. Right?

So how does this fit together? And I think as we look at this, if this is the funding mechanism to help the safety net, then we can't penalize them for being in ACOs and get them kicked out because they're "inefficient"

compared to the benchmark because of socioeconomic determinants of health.

So if you could do any sort of analysis that could sort of tie providers and spend -- like we know who the safety net providers are. Can we look at their average spend versus the benchmarks? I think you'll see the same thing we are, which is a very, very unfortunate adverse selection problem by Medicare. Thank you.

MS. KELLEY: Brian.

DR. DeBUSK: First of all, thanks, Lynn. I feel like that was the perfect setup comment to plug your peer grouping mechanism, so the whole time I was saying, "Peer grouping, peer grouping." So guess what I'm going to talk about?

First of all, I'm really glad to see us address this issue of social determinants, and I think that is tightly coupled, as was mentioned earlier, with their work on safety net payment policies. The two issues clearly go hand in hand.

I do want to start by focusing on the peer group mechanism. I will loop back to payment, I promise. But, you know, it addresses that philosophical question of do

you incorporate SES variables into the risk adjustment models or do you keep them separate. Ledia, you and others here on the staff have covered this so well. Obviously, I'm a strong advocate of keeping those two separate in two different compartments because it gives you the opportunity to make improvements to your peer grouping model, and it also keeps basically contamination out of the risk adjustment mechanism. And I want to mention it's an interesting philosophical discussion we can have, but I'm not even going to fall back on that. I'm going to fall back on the mathematical argument, which is if you introduce a bunch of collinear variables that some are social, some are clinical, and then you start trying to do regressions on them, it isn't impossible, but it is unpredictable and unstable.

So I do think that there's a -- just the mathematical argument alone justifies this compartmentalization, and I want to congratulate you on your first peer grouping breakthrough. You know, moving from fully dual eligibles to the LIS beneficiaries seemed to really improve that model.

So, obviously, a big advocate of that, but I

think the next step, if you look at our work in safety net hospitals, the next logical step, so far all of those peer groups we've been redistributive, we've looked at each peer group, and we've said, well, a 2 percent withhold, let's redistribute money within the group. Well, part of what this peer grouping mechanism does is gives us the ability to not necessarily treat all peer groups equally. In the most affluent peer group, we may very well just employ a redistributive and sum zero strategy.

But as you can imagine, as we move down to the highest risk groups, that's your opportunity to add money to the system, and, you know, Michael, I thought your comment about no free lunch, I mean this is where we deposit the lunch money, it would be into those higher risk socioeconomic groups. Lynn, you'll be pleased -- I don't think you should count against the benchmarks, money outside the system, but I think there's a lot of merit there because I think as we look at social determinants of health and how to address them, one of the fundamental mechanisms is what vehicle do we even have to use Medicare payment policy to influence that?

Now, Pat is going to want us to just lump it all

into IPPS payments.

[Laughter.]

DR. DeBUSK: I had to get my shot in. But, you know, you have to have a -- you do have to have a mechanism to introduce that, and I do think that there's a lot of merit in having a unified platform that does a quality measurement and a bonus and penalties payment system that also becomes the vehicle to introduce new money, because then we can promulgate that across all of our different payment areas. That works for hospitals, that works for SNFs. So, again, I'm really bullish on that, and I hope you guys develop that out.

My own last plug, Ledia, every couple years, peer group first and then let's do the risk adjustment, just to do a quick gut check, because you are making -- if you risk adjust first and then peer group, you are making an implicit assumption that all of those risk adjustment variables behave the same irrespective of peer group. And I'm not sure that assumption always -- you know, discharged to community. I'm sure it works differently for affluent people versus high-risk people. So every two years or so, just think of me, please, and --

[Inaudible comments.]

DR. DeBUSK: Thanks.

MS. KELLEY: David.

DR. GRABOWSKI: Well, that's a hard one to follow. But thankfully, I'm also going to talk about peer grouping, and Brian and Lynn both teed this up really well.

We did make this amazing breakthrough. I found it, as many others did, a little unfulfilling to just try to capture the peer groupings with the full duals, and so this shift to LIS was tremendous progress. And I want us to keep thinking about ways -- and you mentioned during the presentation and in the chapter about collecting data and other ways to even improve on that. But I think we've made tremendous progress. And as Brian said, these peer groupings can be used in a lot of different places, whether it's payment adequacy, whether it's quality reporting, whether it's any of our value-based pay models, identifying and supporting safety net providers. We have this whole set of good candidates here to kind of use this tool that I really think has improved a lot, and I look forward to continuing to see it improve in the coming years.

Thanks.

MS. KELLEY: Amol.

DR. NAVATHE: So I echo my Commissioners in support for this work. This is really fundamentally important, and I'm really happy that we're taking this on.

I think in general this notion of trying to align payment with promoting equity in some fashion or at least recognizing where maybe it's not aligned, I think is a pretty foundational step for us. At the same time, I think there's a lot of wise counsel from many of the Commissioners that preceded me in comments around the point of addressing social determinants of health should not be encapsulated within this notion of decreasing medical spending, and I think we should be relatively explicit if we can in recognizing that, because I think that's not the way that we should be thinking about social determinants of health in a general sense.

A couple other points. I think the chapter did a nice job of teeing up that there's -- you know, value-based payments or alternative payment models are kind of in the future of the work that we're doing, and there are some interactions potentially with how to think about equity or disparities in that context. Here I think it's important

that we recognize that value-based payments and the pursuit of value-based payments is not necessarily translating into equitable or equity -- or equitable payments, and there is, unfortunately, a long history now of different types of programs that we might consider and some design feature or fashion of value-based payments that don't necessarily align with equity. So public reporting, for example, in New York with heart bypass CABG report cards ending up with essentially discriminatory practices against Black individuals seeking heart bypass care. There's participation effects in ACOs. There's been mixed evidence in episodes, some evidence that racial minorities have benefitted, some evidence that lower SES populations have been discriminated against.

So I think we're still figuring this out, and I think it's important for us to put it out there. This is something we're working on. But I think we should be very clear in our minds that value is not synonymous with equity, and there's reasons that we should worry about value-based payments in the context of social determinants of health and equity because we tend to then put a lot of pressure on this notion of risk adjustment, and I think

that's what we've been talking about here a lot in the context of peer grouping and otherwise.

And risk adjustment, of course, is harder in populations that face these social challenges, and the provider groups that tend to serve them tend to have lots of infrastructure to do things like coding, and so it's kind of a snowball effect there that we should be mindful of.

The next point I wanted to make is that I think to some extent -- and there's a little bit of write-up about this in the mailing materials -- there can be an instinctive reaction to say, well, then, we just have to do social risk adjustment and then we're done. And I think that the context for social risk adjustment really, really matters, and it's not a panacea, it's not a silver bullet, it's not necessarily a solution. It may be part of the solution, but it may not be the whole thing.

Now, I think it's important to recognize here that in most cases the populations that we're most worried about are minority populations, and the way that you design the model actually ends up mattering. So if we just put in things like social determinants of health as indicator

variables in these models, they'll still be largely calibrated around the majority population. So you can get -- and, actually, we have seen this -- where you add individual level social determinants of health, think you're doing well, and that actually you're dropping the adjustment for the populations that you're presumably trying to help. And so I think we should, again, just kind of be eyes wide open about these things, which is not to say that we don't want to work on social risk adjustment, but that we should be mindful around some of the challenges in getting this to work.

The last point, and Dana Safran is not here, unfortunately, because I know she would have spoken a lot about the quality measurement side here as well. I think stratifying measures by race, ethnicity, SES status, in my mind, generally speaking, you know, a good thing to pursue. But I think she would articulate that it's quite challenges because these, again, tend to be smaller subgroups. And when you try to get to reliable measures for these smaller subgroups, it's challenging.

So, again, I'm very supportive of the work. I think we should just also in our work outline some of the

challenges out there so that way we're as clear with the broader policy community as we can be. Thank you.

DR. CHERNEW: I think Larry is going to be next, but I just want to jump into some of the themes of what you said, Amol, which is if you look, for example, at REACH, Lynn's concerns of REACH aside, they did try and adjust the spending explicitly to make SDOH or disparity goals explicit in how they set the benchmark by severing the tie between some -- your benchmarks should be your predictive spend and allowing some changes. So I think there is some recognition now in CMS that they can use benchmark policy to achieve other goals. We'll see how far that goes. But to your point, we should pay attention to it, I agree completely.

DR. CASALINO: Yeah, four extremely quick points and then a fifth that will be, let's say, quick enough, at least from me.

[Laughter.]

DR. CASALINO: I only had three quick points, but after what Amol said. So I just want to say I think Bruce and Amol -- first point, what Bruce and Amol I think have already said, but I'll say it in other terms to make sure

everybody understands. If you do a risk adjustment regression and you put in clinical and socioeconomic risk factors, those two are very closely correlated, so you just don't know how it's going to come out, and you could even have the unfortunate effect that Amol just mentioned. So that's important. That's the first point.

The second point is the report does, appropriately, I think, mention public reporting in a number of places quite often, which is great. I think, though, that more explicitness about what we mean by that would be warranted. So public reporting by strata for sure, okay? So if we're stratifying by LIS or dual eligibility or whatever. But also -- and this I think should be explicit -- public reporting in a way that makes it possible, for anyone who wants to, to be able to see both how you're doing within your stratum, but also how you're doing compared to nationally. Okay?

So if you take -- if you're an organization that has a high proportion of poor patients, let's just say, and you're doing well compared to your peers, that's great. But are you doing well in an "absolute way," because you would want to know that too? You don't want inferior care

forever for poor populations. So that's the second point. I would just sort of make that explicit in the report. I don't think there's any controversy about it.

The third point, I think a question we might want to ask explicitly in the report and maybe want to discuss here is: Should there be payment for reducing disparities? I mean, in a way, the way we've recommended paying within peer groups does pay you for reducing disparities. But there could be an additional explicit payment for reducing disparities, and I think that's a question at least worth asking and answering.

The fourth quick point is even quicker, but I think worth considering whether it should be in the report and/or discussed here, is: Should there be payment or penalties for not collecting SDOH information? And if so, for hospitals, for physicians, for who?

Okay, those are the four quick points, and now for the quick enough point. So Bruce has twice talked about medicalizing, and actually that's something that I'd wanted to talk about as well. Some of us here at least are probably old enough to know when "medicalize" was a pretty common term, and now I don't think you hear it so much. It

meant a couple things, but one common meaning was to take a social problem and medicalize it by saying the medical system should take care of it. And in my view, SDOH is a social problem.

Now, it's great that -- you know, you can hear Jonathan's enthusiasm and his sophistication and all that he's accomplished already with the experience, and there are other -- not Jonathans, but there are other people in the same category in the country, and I think that's great. And certainly interventions by organizations that provide care to help their patients with transportation or refrigerators or whatever are great, and there should be some form of payment that makes it so you don't lose money when you do that, even if you don't make money.

So I'm all for all of that. But to just -- but to talk, as almost everybody does and as the report does now, I don't want anybody to get -- I don't want to let government off the hook, all right? I don't want anybody to get the idea that hospitals are going to solve the housing problem for their communities. So I'll say -- I'm almost done. I'll say in just one second what I think could be a very slight modification in the report. But

another way of thinking about is it a medical problem or social problem is population health. Only a few years ago, we went out and talked to medical directors for ACOs, what do they mean by population health. They all meant the health of their attributed population.

Now, people like Jonathan and possibly the other organizations he's working with get it that population health is really the population of a community, not just your attributed patients. But, again, if you medicalize it, it's more your attributed patients. If you think it's the role of government, then it's the community.

So I dealing with be happy if just somewhere in the report there was just an acknowledgment -- it doesn't have to be this wording, but I wrote it out just for myself to understand, something along the lines ultimately intervening to improve SDOH, such as housing, that's the responsibility of government and society more broadly. We don't mean to suggest that SDOH should be medicalized, that is that health care organizations are responsible for improving fundamental socioeconomic determinants of health. What they should be responsible for is taking account of the determinants that do exist in the patients that they're

taking care of and helping address these in ways that can improve their patients' health, and they shouldn't lose money when they're doing it. The payment system should account for that.

So that would be -- it doesn't have to be interwoven through the whole report, just some acknowledgment of that so that we aren't contributing to what I think is the medicalization of problems that aren't medical fundamentally.

MS. KELLEY: Pat?

MS. WANG: Thanks. Great paper and a great discussion, so thank you very much. I wanted to suggest, just sort emphasize, I guess, that as -- MedPAC already does things that touch on this area, and I think just always having a lens that makes sort of the inclusion of SDOH and health equity more intentional would be helpful. So, for example, when you do the beneficiary interviews every year, I think -- the comment has been made. I think it would be important to try very hard to get a good size sample of LIS beneficiaries and to ask them -- to ask them what the issues are. You know, we can ask providers. We can ask organizations that serve folks what they think the

problems are, but I think, you know, having the voice of the beneficiary in there with the lens of we're trying to understand SDOH and health equity for the population would be very good.

The second thing, again, MedPAC has always had a recommendation that quality should be measured at the local level. Through the lens of SDOH, what this conversation -- we're talking about CBOs, we're talking about regional efforts. You know, SDOH is about as hyper-local an issue as you can get, and so I think it's another lens through which to reinforce the recommendation around the measurement of quality at a local level. I'm just speaking from the perspective of a Medicare Advantage plan. The population I serve really is probably very unlike the LIS population in Seattle, but those are -- that's the kind of comparison that gets made in a broad-based national quality program. And so, again, through the -- the recommendation makes sense on its face, but it makes especial sense if you're talking about SDOH.

You know, when I think about what is it that MedPAC can actually do given the specific mandate, and I think what Larry said was really, really important, because

Medicare is not going to solve the housing problem in the United States either. You know, the work on safety net hospitals is really important. I know that there is an intention to broaden that sort of -- that view to providers and physicians, which is complicated, but, you know, payment policy is almost the last step. I think we need to think about what are we trying to achieve here, because we're talking about communities where health care resources and access is very bad. So what needs to happen to stimulate the development of the right kind of health care infrastructure even in those communities could be a perspective when we undertake the work around payment policy for safety net providers.

And I would respectfully ask that -- you know, I won't be here to be bothering you with this, but to also keep in mind the organizations like D-SNPs that serve LIS members. There are very specific things that they need as well. You know, we talked about measurement of quality. I think, you know, the work around trying to come up with adjustments to account for SES status are important, and I hope that MedPAC can continue to support that work through this lens, because those organizations are very much

focused on the population.

On the data collection issue, you know, everybody wants more data. I guess that I just -- you know, and I think it's incredibly important to have it because you can't really figure out where you're doing well. If you want to know, for example, whether your interventions around quality are effective for the Black community or the Hispanic community, you kind of need to know who those beneficiaries are in order to even analyze it. So everybody wants data, and, you know, Lynn's impulse was, like, let's get it all. The one thing that I would just caution us is beneficiaries have a right to decide what information they share, and so the idea of -- because everybody now is saying, you know, collect the race information for your members. We do that for ourselves so that we can analyze, but, you know, you have to explain to people why they should give you that information. Like, what are they getting in return for it? And there are a lot of reasons people don't like to supply information like that. So I think we just need to be very respectful of that fact.

The one thing that -- you know, and again this is

MedPAC, so I don't know how far you get into this, but it would be great if the government itself -- Medicare has a lot of information available to it. Forget tax returns for a second. But, for example, who's receiving a SNAP benefit, if there is any way to incorporate information like that into a beneficiary enrollment file so that, for example, when they join an MA plan, the information is somehow available, because otherwise you have to kind of tease that out of a person through questionnaires and careful questioning and, you know, that's a whole art form. But I suspect that there's a lot of information that is in the possession of government agencies now that serve the population that could carefully be made more available to the people who are trying to take care of them.

The last comment really is value-based payment is the way -- if you want to talk about payment policy, it is really hard for me to imagine the kind of -- so SDOH, and addressing SDOH is obviously a gigantic team sport. Gigantic team sport, and everybody has to work together. CBOs are really important. State government is important. Health care providers are important. And in my view, VBP is really the best way to align that, not one person having

all of the risk, but sharing the risk so that people are aligned around what they're trying to do for somebody. And in that regard, you know, Jonathan I think said the importance of states. Medicaid is really important. So just even figuring out Medicare staying in touch with the efforts of Medicaid agencies. People don't develop complications from SDOH when they turn 65. It starts a lot earlier than that. So just having the longitudinal view I think is really important.

Thank you.

DR. RAMBUR: Thank you. I really appreciate the chapter and the comments from the Commissioners. Just three quick points.

Bruce and Larry highlighted the issue of medicalization, and I just want to also add another point on this, health care taking on issues that are social issues or public health. Health care is where all the money is. Medical care is where all the money is. And there was a study I'm sure you've all seen many years ago in the Boston area that 88 percent goes to traditional medical care, disproportionately surgery, whatever, so that's part of the reason. And we also benefit in medical

care when we don't address social determinants and people get sick, right?

One other quick point. Where's all the public health nurses? Well, that's been systematically cut over the past decades.

So when we look at other countries, at least, you know, what I've seen, overall the expenditures are the same if you aggregate social services and medical care. It's just that we spend so much more on medical care and less on social services.

So I think these are important things, and they lean into my next point. I hear Amol on value design, equal equity, and I certainly agree with that. And yet risk-bearing population health models, as Pat pointed out, I believe really begin to align the economic incentives to it; otherwise it's altruism, and so how do we assure that that happens?

So that gets to my idea to pursue that I have no idea how this could be done, and I don't expect an answer, but to think about how do we expand the accountability horizons or the outcome measurement horizons, because how a person is at 65 has a lot to do with, as Pat said, a lot of

things that happened before then. How they are at 80 has a lot to do with what's happening at 65. So chronic condition prevention and management is a very long-term issue, and yet we have organizations and facilities that are really looking quarter by quarter. So that would be my plea, is there some way to expand that horizon that's embedded in the payment models?

Thanks.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you, and thank you for a great chapter. I think I want to follow up maybe on Larry's point about thinking about some of the data issues and also thinking about it from a claims data issue. I notice that there are Z codes that CMS has put together for capturing some of this, and I think it's one of those things where we know people won't use codes unless we pay them to use codes. And then I'm like fighting with myself of do we pay them to use codes or do we -- like Lynn, pay them to do it, you know? But then, you know, you look at the list of recommendations, and it's like invest in a good EHR to help you. Well, that probably disadvantages some sites that maybe want to do more of the actual work, or

creates a situation where we're putting more money towards groups that are collecting this more routinely, but maybe they're not doing anything about it.

So I think there's this kind of interesting need to know the scope of the problem, would love to be able to adjust for this, but also don't know if just saying you have people who you're treating who have housing issues or other things, it's like, well, whether you're doing anything about that seems like what we'd like to know. So that's just maybe a comment of -- I don't know how we could get people to use -- I know how we could get people to use those codes. I don't know if we would get useful from those codes even if we had them using them. You probably both feel the same.

And I think the other just very broad one comment was on the background, thinking about in the box that defined some of the key terms. You mentioned the social determinants of health and thought maybe it would be worth thinking about explicitly mentioning racism and structural racism as part of that.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Thanks very much. I wanted to come

back to Dr. Riley's Round 1 question where he asked, what is the chassis for effectively addressing adverse social determinants? You know, we've had a very peripatetic conversation about what is within the sphere and what is outside of the sphere, and I think that's obviously an important clinical conversation. But to me, I think there is a qualifying aspect, and so I want to offer four comments that are really based on a lot of just direct front-line and organizational operational experience. And I think there's a way to parse it and those things that are immediately relevant needs. And what do I mean by immediately relevant? Those things that without, you know, timely intervention will invariably lead to immediate deterioration in clinical status or predictably lead to increased costs for the therapy. So I think there's a way of parsing that aspect.

Second, we obviously need then some way of qualifying the individual or the institution that's affected by adverse social determinants. We need to know then what we want to do with the data.

Here I'd channel a couple things. First, from Dana Safran, I think she also would have said one other

thing in addition to your comments, Amol. I think she would have said we never, ever implicitly or otherwise want to condone a condition in which there essentially, even by a transitive function, is reward for inferior outcomes in an adversely select population. I'll give you an operational example. When I was leading the VA health system, I mean, you know, yeah, it was more difficult to get a pneumococcal immunity in patients with extreme adverse social determinants. But there was no population for whom it was more important to get that. So, you know, it actually was not something that I chose to stratify, having the opportunity, you know, to lead that system. I wanted to make sure that everybody got that, while recognizing the challenges.

How do you get those data? I think Pat and Stacie made this point. This isn't easy. It takes resources. And even if you said, okay, here's some dollars for Z codes, let's dissect what it really means to get these data. You know, who is it that acquires the beneficiary characteristics? Well, usually at admission into a hospital or admission into a clinic, there is a person who's clerical in nature. Somebody alluded to the

fact that some of these questions are sensitive. They may be matters of pride. They may be matters of personal privacy, et cetera. And we do a really poor job already on getting the real data, race/ethnicity, and language, let alone getting into qualifications on income, let alone getting to SOGI and the like.

So I think, you know, implied behind that is the need to develop skills in eliciting what are sensitive and complex data. And, oh, by the way, if you get those data, do we have the conventions to reliably categorize, store, manage those data? Having an EHR isn't enough. I had the opportunity to chair the Health IT Standards Committee in 2009. There were actually 26 codes for gender identity. And, you know, this is really tough stuff if we're serious about it, and so we need to lay in an infrastructure as part of a plan if we wish to get that.

So, one, you know, what's the chassis? Two, what do we hope to accomplish with data? Three, how do we get the data?

And then, finally, you know, in terms of being able to intervene, maybe our focus is so -- maybe our focus is personally misdirected. I think we need to identify

safety net institutions, but I don't want to say safety net individuals or safety net patients. What I want to say is patients who are rendered extremely vulnerable by virtue of adverse social circumstances. And for those individuals, you know, what is -- returning to the first part -- the mechanism for intervention? You trust me by virtue of my medical license to write for multi-thousand-dollar prescriptions or multi-tens-of-thousands-dollar procedures. None of those have been my most efficient prescription. In VA, for a patient with end-stage emphysema, COPD, the most efficient prescription was for a $600 window air conditioner. It changed as an immediately relevant vulnerability the trajectory of an individual living in a double-wide trailer in Richmond from coming into the hospital twice a month, you know, in extreme circumstances, to coming in predictably twice a year for organized care.

So I just offer that operational perspective and hope we can change the focus into practical mutations from across the continuum from data to intervention for our beneficiaries. Thanks.

MS. KELLEY: Jaewon?

DR. RYU: Yeah, my comment was also around this

idea of medicalization, and I think it's a balance, and I like how Jon Perlin mentioned a few things that I think are relevant for this. But I agree with Larry, you know, you don't want to medicalize this. It's certainly not the reason to do this work. And I also agree that the delivery system and payment policies are not the silver bullets to solve for this. These are big, big issues.

But at the same time -- and I think Betty said this well -- I think it's still a huge part of the solution, and so I do think that there's a role, and it is where the dollars are at. I think there's a role to be played by the delivery systems out there, provider entities, what have you. And I think especially in areas where I think Jon used the word, you know, sort of proximity or proximate areas, like food is one that I think is very proximate to clinical outcomes. And I think those areas health care should play a role and payment policy should play a role, versus something that may be more remote. You know, I think that gets a little attenuated.

And then the other is, you know, Pat's comment around payment policy should be the last step. I agree with that, too, but I do think it is still a step. It is

still one of the arrows in the quiver that can really help and certainly shouldn't be something that adds more barriers to the work. It should be something that, you know, is a tailwind more so than a headwind.

Lastly, this notion of value-based payment, I think Amol's comment, I agree that, you know, that's not synonymous with equity. But I think fee-for-service is even more not synonymous with equity. And so between the two, I think it's still a pretty compelling reason to move towards the value-based payment models.

DR. CHERNEW: I think where we are is we're now at the mythical Round 3.

[Laughter.]

DR. CHERNEW: This might just be Round 2-B or something, but I think we have Lynn and Bruce who are going to loosely close us out. So, Lynn, I think you're next, and then -- oh, we just have Lynn.

MS. BARR: All right. Round 3 is me. I really appreciate what Jonathan's saying about -- and other comments about operationalizing this. My head is in the exact same place. Where do I capture the data? And what is the minimum data set that actually is a determinant of

health? So, you know, what I see and what I get concerned about is, okay, now we want to -- you know, we'll have 26 codes for gender. You know, nobody's going to be able to use those, right? But we have a mechanism today -- the annual wellness visit -- where we do a health risk assessment, right? And it is not difficult to ask a few questions. They don't have to answer, but I want to know do they have transportation, do they have food, and are they eligible for the LIS.

Now, we're actually putting that into our health risk assessment at Caravan because we want to go out and sign up all those people that need the LIS subsidy, right? And so that's three diagnosis codes, right? Food insecurity could be a diagnosis code. Below the poverty line, you know, the LIS poverty line, would be a diagnosis code, and also looking at -- what was my third point? I don't remember. Transportation. Because as you noticed in your paper, those are the three things we work on, and it's the only three things we work on because the problem is we can only do so much, and those are the big, big impact ones. Transportation will save the government a ton of money in unnecessary ambulance fees, et cetera, and unmet

care needs.

So, at any rate, I think there are ways to make this happen efficiently. Thank you.

DR. CHERNEW: So that's going to take us to the end of this. I really do appreciate the I think universal passion around this topic. I really appreciate the acknowledgment that we are MedPAC and we recognize these issues should not be medicalized, so we have to be quite practical in how we go about this. Again, in other work and other places I've been, if you ask me what to do here, I would start off with like early childhood interventions. It turns out MedPAC is not really the best place to have discussion about early childhood interventions.

But, nevertheless, I think there are and there have been several examples of things that we will continue to think about in our work. They range from data to measurement to interventions to incentives and a whole bunch of other things. It is a complicated area. I'm glad we are taking it on, and we will continue to do so.

For those of you who might not have noticed, and for those of you at home, this material that we've been discussing today is not going to appear in the June

chapter. This is an informational discussion like the rebate work as we begin to plan out our agenda and to get a sense of the temperature of where everybody is, and I think we've done a really good job of doing that. So I'm grateful to the setup for this and for all of you for commenting, and so I think for Ledia and Geoff, you did a great job. You have a lot more to do, so that's all good.

For those of you at home, please send us your comments on any of this for this session or this morning's session. Just mail them to meetingcomments@medpac.gov or go on the Web and find under medpac.gov public meetings and past meetings. You can send us comments. We really do want to hear what you have to say.

To the staff, the many of whom have put together this new era of how we meet, thank you very much. It may have looked like it was effortless. It was not. And to the Commissioners who adopted sort of this new version, thank you very much. It was really great. I wish we weren't doing it the last meeting of the year, but it's nice that we got to do it.

So, anyway, thank you all. We will be meeting again tomorrow at 9:00. We'll be talking starting with

alternative payment models and then site-neutral, but for now I think we're going to sign off, and thank you all.

[Whereupon, at 4:54 p.m., the Commission was recessed, to reconvene at 9:00 a.m. on Friday, April 8, 2022.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

-and-

Via GoToWebinar

Friday, April 8, 2022
9:01 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
PAUL B. GINSBURG, PhD, Vice Chair
LYNN BARR, MPH
LAWRENCE P. CASALINO, MD, PhD
BRIAN DeBUSK, PhD
STACIE B. DUSETZINA, PhD
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AGENDA PAGE

P R O C E E D I N G S

[9:01 a.m.]

DR. CHERNEW: Welcome, everybody, to our Friday morning MedPAC. We have a great agenda today and we are going to jump right in. We're going to start with a discussion of alternative payment models with Rachel, Geoff, and Luis. Who is starting? Rachel. Okay. Take it away.

MS. BURTON: Good morning. In this session, Geoff Gerhardt and I will describe an approach to streamline and harmonize Medicare's portfolio of alternative payment models.

Our colleague Luis Serna will be on hand to join us in answering any technical questions Commissioners have, and we'd like to thank our colleagues Jeff Stensland and Betty Fout for their input into this presentation and paper.

For those watching online, a copy of these slides is available from the control panel on the right side of your screen, under the Handouts section.

In last June's report to the Congress, the Commission recommended that CMS reduce the number of

Medicare alternative payment models it operates and recommended that the agency design models that work better together. In subsequent meetings, Commissioners have explored how to operationalize this recommendation, and have offered more specific suggestions for CMS to consider. These are described in the draft chapter shared with Commissioners, and will be the focus of today's presentation.

I will recap Commissioners' input on population-based payment models, and Geoff will recap Commissioners' input on episode-based payment models. We seek feedback on whether we have accurately captured Commissioners' views, and ask that Commissioners identify any revisions that might be needed before this material appears in our June report to the Congress.

Commissioners' initial APM discussions this cycle focused on population-based payment models, which are also known as models for accountable care organizations or ACOs. ACOs are groups of providers that have agreed to be assessed based on the annual cost and quality of the care provided to patients seen by their primary care providers.

Currently, providers have seven model tracks to

choose from, spread across the Medicare Shared Savings Program and the ACO REACH model, which used to be called Direct Contracting. If CMMI launches additional models, the number of tracks could grow.

Currently, providers report needing to invest significant resources to sort through these options and pick a track, and there is no single default model for other payers to base their payment arrangements on. A simpler approach, favored by Commissioners, would be to reduce the number of population-based payment model tracks, and to use more consistent features.

Although Commissioners are not wedded to a specific number, many would support dropping down to three tracks. For example, one track could be geared toward groups of small provider organizations, such as independent primary care practices, and could offer them the chance to keep 50 percent of the savings they generate relative to a spending benchmark.

A second track could be geared toward mid-sized organizations, such as multi-specialty physician practices with multiple locations and small community hospitals with a modest number of primary care providers. Providers in

this track might keep 75 percent of their savings and owe 75 percent of their losses relative to a benchmark.

A third track could be geared toward large organizations, such as health systems with multiple campuses, and could let providers keep 100 percent of their savings and owe 100 percent of their losses relative to a benchmark. Small and mid-sized organizations that want to take on more financial risk could be permitted to participate in a more advanced track.

Commissioners' other suggestion for population-based payment models is to stop periodically "rebasing" ACOs' spending benchmarks. In ACO models, benchmarks are often based on historical spending data that is then trended forward to the current year. This trending forward continues for a few years, and then benchmarks are set anew, using more recent spending data, and the cycle starts over.

If an ACO generates a large amount of savings, as the illustrative ACO in this graph did, then each time benchmarks are rebased, they have the potential to be ratcheted down, shown in the yellow circles. This means ACOs are effectively penalized for generating savings,

through harder-to-beat benchmarks.

Commissioners favor getting rid of periodic rebasing, as shown in the orange line. This would get rid of the kinks in our graph, and cause ACO benchmarks to increase at a steadier rate. An ACO whose benchmarks follow the orange line's trajectory could be expected to have stronger incentives to lower spending, since doing so would not cause them to be penalized with lower future benchmarks. For example, in this ACO's case, within 15 years a continually updated benchmark could grow to be $1,000 higher than it would otherwise be under rebasing.

Commissioners envision setting benchmarks using historical spending at the start of an ACO's participation in a model, and then trending it forward without any periodic rebasing. The trending forward of benchmarks would be done using some kind of growth factor that is exogenous, meaning it is unrelated to ACOs' actual spending. This could be a single factor or multiple factors.

For example, a price growth factor could reflect annual updates to Medicare's fee schedules, and could be coupled with a volume and intensity growth factor based on

CMS actuaries' Medicare fee-for-service projections or the projected growth in real national GDP. This volume & intensity growth factor could then be discounted by some percentage, to generate savings for the Medicare program.

It is especially important to grow benchmarks at a slower rate than current fee-for-service spending in the model track that would allow providers to keep 100 percent of savings relative to a benchmark. Otherwise, no program savings would be generated from this track.

I'll now pass things over to Geoff.

MR. GERHARDT: Now we'll turn to approaches for episode-based payment, which are focused on improving quality and reducing spending during specific episodes of care, such as knee replacement surgery or a hospital stay for congestive heart failure.

At the March 2022 meeting, Commissioners supported integrating an episode-based payment model with the population-based approach that Rachel just described. Having Medicare administer a nation-wide episode-based model alongside ACOs is seen as desirable because episode-based payments can help focus care improvement activities on specific episodic events, but such arrangements can be

burdensome for ACOs to set up and administer.

At the March meeting, most Commissioners supported an approach where all fee-for-service beneficiaries would be attributed to a Medicare-run episode model if they trigger a covered episode. This would include beneficiaries in one-sided ACOs, two-sided ACOs, and beneficiaries who are not in an ACO.

Just to be clear, any beneficiary in an ACO who triggered an episode covered by Medicare's model would be concurrently attributed to providers in both models during the episode. But once the episode period ended, they would just be attributed to their ACO.

For any type of episode not covered by the Medicare-run model, ACOs would have the freedom to design and implement their own episode-based payment arrangements as they saw fit.

In the next two slides, we present six factors the Chair has suggested CMS take into account when selecting which types of episodes to include the Medicare-run model.

First, the agency could consider whether an episode has attributes that facilitate episode-based

payments, such as whether there is a clear triggering event and whether the episode is conducive to setting benchmark prices accurately.

Second, the agency could take into account whether an episode has been found to generate savings and/or improve quality relative to what an ACO would have achieved on its own, in the absence of an episode-based payment model. And in order to guard against the possibility of inducing growth in episode volume, CMS could consider whether adding an episode to the model will lead to an increase in volume for that episode.

Next, CMS could take into account whether inclusion of an episode in Medicare's model is likely to discourage provider participation in an ACO. For instance, incentives to participate in an ACO may be dampened if bonus payments for efficiency gains during an episode go primarily to the episode initiators and not to the ACO.

CMS could also consider how care is typically managed and delivered in different types of episodes and how those processes interact with how ACOs manage care for their patients. For example, since beneficiaries often have multiple chronic conditions and these conditions are

usually managed through ongoing, rather than episodic relationships with providers, Medicare should be cautious about including episodes for chronic conditions.

And finally, CMS could consider whether including an episode in its model would be expected to reduce disparities in access to care and health outcomes.

Evaluations of Medicare's current episode-based payment models do not include assessments of many of these factors, so it is difficult to know which, if any, types of episodes would meet them. As such, the six factors could be presented to policymakers as general principles for CMS to consider rather than hard and fast criteria which must all be met for an episode to be part of Medicare's model.

Another important consideration is how savings or losses generated during covered episodes should be allocated when beneficiaries in an ACO trigger an episode in Medicare's episode model. The optimal approach will depend on specific design features of each model, such as how spending benchmarks are calculated and the mechanisms for generating Medicare savings.

Therefore, instead of getting too specific, it seems preferable to present a high-level set of principles

for how payments, or repayments, resulting from changes in spending during episodes should be allocated between participants in the two models.

The first part of the proposed principle is that episode-based providers should have a large enough incentive to furnish highly efficient, high-quality care. Second, providers in ACOs should have enough incentive to refer patients to low-cost episode-based providers. Finally, when these incentives are combined, they should not be so large that total Medicare spending ends up increasing.

That concludes our presentation on specific strategies for streamlining and/or harmonizing Medicare's portfolio of APMs. A chapter on these concepts will appear in the June 2022 report to the Congress. In developing that chapter, we seek feedback on whether this presentation and mailing material accurately summarize Commissioners' preferences. We are particularly interested in your thoughts about the episode selection factors, since those are new since last month's meeting.

We look forward to your discussion and I will now pass it to back Mike.

DR. CHERNEW: Great. As you know, I'm really happy and impressed with this work. I think we've gone a long way from the beginning of the year. So before we jump into the round of questions, I'll give my personal thanks to all that you guys did.

That said, we are ready to go with Round 1, and if I have this right, Stacie, you are the first in the Round 1 queue.

DR. DUSETZINA: Thank you. This was a really great report. I really appreciate it, I just had a question about, on page 5 of the reading materials there was a comment about the shift in how payments would be made, removing the 5 percent and shifting to the growth rate. And I was just curious if you had any kind of idea of how much participation could grow as a result of that change and whether or not it might be something worth commenting on in the chapter. I realize it's kind of reading into the future.

And the other part related to that was I wasn't sure if there was a threshold for receiving that payment or just was the payment added to all services.

MS. BURTON: Are you referring to MACRA's 5

percent AAPM bonus?

DR. DUSETZINA: Yes.

MS. BURTON: I think we probably could not comment on how we think that change in 2026 is going to affect participation in A-APMs because the MIPS performance incentives actually get quite large then too, like 9 percent. So some really top-performing ACOs might actually not want to qualify for the A-APM bonus but they might want to still be in ACO because top-performing ACOs tend to be the top MIPS performers. It's kind of a long way of saying that there will still be probably pretty good incentives to be in an ACO.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. At the March meeting and also in the chapter we have made, I think, appropriate -- oh, by the way, this was a really good chapter, I think. I was pleased to how it came out. But we make a fairly big deal about rebasing and the ratcheting effect that that has on ACOs. And I think that was really one of our main points last time and in the chapter, that that's very undesirable.

But for episodes, that's basically what the

chapter recommends. And I'm not sure there is a solution. You guys seem to think that the exogenous administrative trend idea would not work for episodes.

So do you have any further comment on that, because does seem a little inconsistent that this is almost like a fatal flaw of the ACO program, but yet we'll do it in the episode model.

This is not your fault, by the way. This is an inherent problem.

[Laughter.]

MR. GERHARDT: Mike, you have your microphone on.

DR. CHERNEW: I do, but if you want to speak, feel free to talk first. Otherwise I will jump in on my thoughts on this.

MR. GERHARDT: Well, I was just going to point out that because episodes are relatively narrow, you know, over time, as well as service use, compared to ACOs, which are total cost of care, you know, over the entire year, it's kind of important to get the prices close to what the actual counterfactual is, the expected prices.

CMS has had problems with some of the models that they've run, episode models, when the expected prices are

quite different from what ends up in the target price can lead to -- just is on alignment, which makes it difficult to either get a bonus or paying too much bonuses, which has been what's happened.

So I think, at a general level, it has been more important to be accurate in terms of expected prices for episode-based payments, which is not to say that there couldn't be other ways of doing it. But it's just harder to conceive of, given the differences of how the models work.

DR. CASALINO: I think you expressed that well in the report. Sorry, Mike, one more. Do you think the ratcheting effect is important in an episode-based model?

MR. GERHARDT: I think it can have some importance, but, I mean, we've talked to folks at CMS who say despite the fact that the target prices have continued to come down for things like a hip or knee replacement, they still see strong participation in the models that deal with those.

So yes, it's a phenomenon. It may affect participation at some point. But at least so far, they don't think that it has.

DR. CHERNEW: So this may lead into a Round 1 question, appropriately, which leads to a Round 2 answer. But again, I suspect Amol has strong thoughts on this as well. I'm going to give a version, Amol. If you want to jump in, I think that might be useful.

The challenge, I think, in the episode case, unlike the ACO case, is there's wide variation in growth across episodes in a whole range of ways, so it makes the solution much harder to implement. So in some sense your point, Larry, I agree with. Ratcheting is a problem in episodes for a range of ways. I think conceptually I agree with you. But figuring out what the right solution is is much harder than I think it is in the ACO world, where I think you can average out, broadly.

It's one reason why I think population payment models are easier to manage in this way, because the episode models, because of their inherent narrowness and the variability to cross them, you couldn't impose an administrative-type benchmark as easily in episodes because the swings -- you would be way, way more inaccurate trying to solve that problem in episode than I think you will be in ACOs.

DR. NAVATHE: If I can jump in. So I think there are a couple of different concepts, I think, that are worth highlighting. I think what Mike is alluding to is that trying to do an exogenous administrative-type benchmark in an episode would be very challenging because it varies tremendously from market to market. And I think that's true.

I think does the ratchet effect potentially hurt participation? I think it really depends on the design. If the design, as many of the more recent models have shifted towards a regional or market-type benchmark, whether there's really, truly a ratchet is actually a good question, and I think what you're hearing from CMS makes sense. But I think that the context is that it's a market-type benchmark, which is a little bit different when you think of ratchet.

If you think of a historical benchmark that's episode-initiator or provider-specific, then the ratchet certainly will affect participation because you're taking away the ability for them to make margin, I guess, against a historical benchmark. So I think that's kind of how I would think about it.

MS. KELLEY: Brian, did you have something on this point?

DR. DeBUSK: Super fast. Larry, great question. And, Amol, I would even ask you, if we look at ratcheting effects, let's get really specific: lower joint replacements. You watch BPCI hit; all these physicians started doing anterior approach hip replacements. They started managing post-acute care. I find it hard to believe that some of that didn't spill over and become standard of care. And you have to wonder. I mean, are bundles falling a little bit victim to their own success? And isn't that more proof that bundles are working?

DR. NAVATHE: That's a great question. I would argue -- and I actually have in written form -- I think all APMs are a victim of their own success to some extent. I think what you're pointing out is really appropriate, which is that the secular trend in many of these episodes, certainly hip and knee replacement, is a great example. The secular trend has been fairly aggressively downward in that the markets have gotten -- generally speaking, market participants have also gotten more efficient over time.

There is evidence that there are some spillovers.

We've done some of that work. The spillover sizes are not as large as the mean effects of being in the program, so I think the answer to your question is probably a little bit of both. You know, there's a little bit of spillover effect, but I think, in general, there has been a strong shift, partly catalyzed by ACOs probably also in the market of becoming more efficient. I think it makes Mike's point earlier very important, which is that that's one of the reasons it's so hard to do administrative type benchmarks in episodes. So hopefully that answered the question.

DR. CHERNEW: We should move on to the next clarifying question. This will hopefully come up again, because the key issue here is this will vary across different types of episodes, so you need to think through this when you're deciding what episodes to watch. I think the joint episode is an example where we think that's a really good successful area where the episodes have actually worked well, my understanding is, and I do think there is a sense in which organizations would be a victim of their own success, collectively. If you mandated everybody in and everyone was successful, then the regional thing would move down, and it would be harder, and we would

need to think through how to deal with that. It's much harder to do -- it's much harder to figure out how to think through that in an episode basis. I think the hip and knee allows some flexibility in how you think about that, more so than possibly some of the other episodes.

So the way the chapter's written, this just ends up being a consideration of how that's going to play out, but you're going to have to think about it differently across different conditions and different types of conditions. That's my sense of how CMS will ponder it.

DR. PAUL GINSBURG: If I could just say one thing. I think this notion of success, rationing down payment, that's how markets work.

MS. KELLEY: Lynn.

MS. BARR: Excellent, excellent paper, and actually my question was also on the growth factors, but not as related to bundles but as related to ACOs. And it also has -- but I think the concerns I have are the same. We talk about regional benchmarks. We talk about, you know, national trend. And those are guiding lights, right? But we have different trends in the safety net than we do in the rest of the population. So fee-for-service

physicians aren't going to get a raise for ten years. All right? That is artificially, you know, capping growth in fee-for-service payments. But if you provide those services outside of the fee schedule, you're on a normal trend, right?

And so I don't see how this promotes health equity because we're averaging everyone as if all the patients and all the payment models are the same, and they're not. And so what the safety net is doing is artificially increasing the trend for everyone else, but we're small enough that we're just going to get slaughtered by these trends, as we are today. And I'll have more to say about that in Round 2.

So my question for you is: How would you design this to promote health equity?

DR. CHERNEW: I'm not sure that's going to be Round 1, but I'm going to say something -- is it okay if I talk? I'm going to say something quickly. The way in which that has been done -- and I understand you have some issues with the REACH model -- is the actual adding on specific factors to deal with those issues for particular groups in a certain way. The implementation of that is

more detailed than I think we're going to get to in this chapter, but the framework enables them through structures of REACH. The implementation is a different issue. So you can manage the benchmarks in ways to deal with that once you have that as a criteria for what you should do. That's true for population-based and otherwise, so there's an execution and there's a conceptual problem. In REACH, they've tried to particularly address that --

MS. BARR: [Off microphone.]

DR. CHERNEW: I understand, but you could take the concepts that were in REACH and put them in MSSP. You could decide that you wanted to add safety net bonuses to aspects of where the benchmarks are. You could decide you want to take the benchmarks and adjust them in the peer group. There's a lot of ways you could do that in the MSSP -- MSSP is now.

MS. BARR: Right.

DR. CHERNEW: But the question you asked was not what's good or bad with MSSP. The question you asked is how would you design it, and the answer to how you would design it is you could build into the benchmarks the goals that you want to make sure that you're not systemically

underpaying for populations that need systemically more payment. That's not --

MS. BARR: So shouldn't that be part of our recommendation then? Because our recommendation does not include any of that. So this is my --

DR. CHERNEW: Okay. So, first of all, two things. This is not a -- there's no recommendations. Just to be clear for those listening at home, there's no recommendations here, right? There's no votes. This is, you know, a broad conceptualization of how we do it. We can look through how the language works in the chapter, on how they support equity. In other contexts we have pushed, this is an important principle in a range of ways. But relative to the sort of broad framework, I think it's a very important point societally, but I don't think it's a change to the sort of basic structure. It is a recognition of something that we care about that we could discuss in the chapter, so we'll look at that. But I don't think it's -- I don't think it's a broad design change at the top level, like you don't have to get rid of ACOs or add episodes in. It's just when you set the benchmarks, consider this other factor.

DR. CASALINO: It might be worth noting that in the chapter, though.

DR. CHERNEW: Yeah, I totally agree, right. So I think Bruce is next. Is that right, Dana?

MS. KELLEY: Yes.

MR. PYENSON: Thank you. I enjoyed the discussion of administratively set benchmarks, and I'm wondering what your thinking is of the differences in trend. Lynn just -- it's always nice to hear from the rural segment, but there's many other segments, including urban, non-participants in the MA. And the way that -- I guess that Paul -- some of the options presented were to use Office of Actuary trends and things like that. Is there -- what are your thoughts on segmenting that to either ACO participants, non-MA, chopping up the trend to reflect the different selections and different segments in the Medicare population?

MS. BURTON: I think we would defer to you guys. That's something you could definitely discuss during Round 2 and debate the pros and cons.

MS. KELLEY: So I think that does bring us to Round 2.

DR. CHERNEW: Perfect. And number one in Round 2 I think is Amol, and then we'll go from there.

DR. NAVATHE: Thanks, Mike. So, first off, I really wanted to thank the staff. I think you have pulled the proverbial rabbit out of the hat here. I think there's a tremendous amount of work that you've done to stitch this together from the previous meetings where we discussed population health episode and actually bringing it together in such a cohesive and cogent way, very challenging, and I think you pulled it off. So major kudos to you. And I think the addition of some of the pieces that kind of link together, like the considerations, have been a particularly nice enhancement, so thank you so much for the work. Very supportive of it, of course.

I'm going to organize my comments basically the way that the mailing materials flowed, which is by population health and episode and then the two together to some extent.

On the population health side and ACO side, the first point I wanted to make is that we mentioned strong participation incentives. I think we're not very specific about what we mean there, and I thought, in fact, it might

be good for us as a Commission to debate a little bit or discuss what we mean by that.

To me it seems like there are three different flavors of participation incentives. There's one which are kind of the carrot approach of let's make this really attractive financially to get providers in. A second flavor is to try to make essentially kind of some sort of downside or specific lack of participation, so almost like a penalty or a mandate or something to that effect. And then a third type is I think what is in the MACRA legislation, which would be let's have some really broad policy that makes fee-for-service a little bit less attractive and the APM participation more attractive. We're not very clear about what we mean there, and I think it would be good for us to discuss.

I will just put my one nickel down here, which is I think right now it seems like we have our 1 and 3, which is some positive things, and there's a general trend for MACRA. I'm worried that by itself we might not be able to get it done with just 1 and 3 to get the broad type of participation and the goal of every beneficiary should be aligned basically to an ACO or an APM or some sort.

The next comment I had was we discussed about the concept of voluntary selection, which is basically that providers are more likely to participate if they think they can win more or less. And I think the evidence on this is a little bit mixed relative to other areas. I think, for example, the idea of midstream opt-out is much more pernicious and has been, I think, more concretely described. It was, in fact, in the prior mailing materials from the prior ones, and I think it got removed. So I would just suggest that we add that back and maybe soften the language a little bit about the voluntary selection on treatment gains kind of effect.

The third point here, we mentioned in the context of the way that we could structure this size as the way to partition essentially between the different tracks, and, in fact, one of the options was based on the percentage of or the size of your beneficiaries that are attributed, you could then have a continuous relationship with the percent of risk or percent of shared savings.

I think size is an important dimension, but it's only one dimension, and we should be careful from having a formulaic approach there because there are smaller groups,

if you will, that have greater capability, and we would want them to be able to opt in, if you will, to an even higher track. And so there may be reasons to keep organizations from going down a track, but we would want to have the flexibility for them to move up.

The next point is around the administrative benchmark. I think the write-up does a very nice job of articulating that there might be reasons to have flexibility if the annual benchmark ends up not quite working out the way that projections may have taken. I think we should be careful in that language to ensure that we're still talking about it as an exogenous benchmark and not something that gets negotiated in some way, but specific ACOs or specific regions or something like that. The language to me feels a little bit like it could be ambiguous about that, and I think we just want to be clear.

Next, shifting to the episodes section, the first comment there is we lost a little bit of the literature that was in the prior mailing materials from March around the potential benefits that can exist between ACOs and bundles and what we've learned from the empirical literature, and I would just suggest we take that language

and put it back in, certainly highlighting that there's less evidence about overlap than there is for each payment model type alone.

I think ACOs can be a really important buffer against volume expansion, which is one of the concerns in the considerations. I think it might be nice to actually put that out there as a benefit of this so-called interaction.

The next point there is in the considerations we nicely have laid out that the way that we might make decisions about which episodes to pursue or ones that are expected to generate net savings, and that I think is really important to highlight that expected point, because historical programs have certain designs that have flaws, as Brad Smith and others have outlined and you have referenced. So we need the flexibility to guide CMMI basically, or whomever, to say, well, as you may design enhancements, can we expect that we would get savings rather than having to look back at potentially flawed historical programs.

The next point is an important one, and this is where the framing between the paragraphs that come after

the considerations and the considerations, I think, are a little bit different, specifically around being cautious about adding bundles or adding episodes. I think it's clear from your other write-up that there's strong Commissioner support for having episodes in parallel, and so I think while we certainly want to articulate that, these are intended to be coordinated, and so we want to consider the impact of episodes on things like ACO participation. I think we should also be careful to sync the wording with this notion of the Commissioner support for episodes in general.

Next point, we talked a little bit about the historical benchmark and ratchet effect in episodes. I think one rational way to think about this would be to have not an administrative benchmark but a historical benchmark for episodes that are trended forward by the actual spending in a market as opposed to an administrative exogenous trend, and that might be able to actually bridge the gap between what we're concerned about with admin benchmarks but with actual observed trends.

Last point on episodes is that physician groups are a really important large participant group in episodes.

We at the present moment don't really acknowledge that. It seems very hospital focused, so I would just suggest that we add that just for fair representation.

On the coordination between ACOs and episodes, I have one point which I think is hopefully an important one to get reactions from other Commissioners on. I think to some extent the way we have framed this is as if the ACO and the episode provider are kind of pitted against each other in terms of the benefits, the savings, and how they get divided. And I would propose that ideally, we could add a consideration here that we could, in fact, not have this be a zero sum between the two, between the episodes and the ACO providers, but, in fact, that there would be benefits to coordination; in fact, the benefits could be created independent, quote-unquote, of one another in terms of how the financial accounting works. I think that would be really important from the sort of political perspective going forward of understanding that these are two programs that are intended to work together, not pit one against another.

The last point I had is just we mentioned equity in the context of episodes, but we don't really mention it

-- and Lynn has kind of articulated this to some extent -- in the context of ACOs. I feel like it's an important point that maybe we can just elevate into a preamble section and say all of the models that we're going to look at, regardless of what they are, will have an equity consideration.

So thank you. Really, really great work. I'm very excited about the work that you've done here and express support for this direction. Thank you.

MS. KELLEY: Lynn.

MS. BARR: Thank you, and thank you for an excellent chapter, and I do believe we've made a lot of progress. And I am 100 percent supportive of everything that's written in the chapter. I don't feel like you got anything wrong. I just feel like we're not talking about the elephant in the room.

You know, my company represents safety net providers and accountable care organizations. About half of them are rural; about half of them are urban. And we're getting slaughtered in the program with regional benchmarks. The regional benchmarks are totally inappropriate. They're set by a predominantly fee-for-

service environment. And what concerns me about this chapter is we didn't address the issues of health equity that are caused by these regional benchmarks.

And so as we are forced to take more and more of a regional benchmark instead of a historic benchmark, it's forcing the safety net out of the program. And I think my friend here from Milliman will tell you that everyone's looking at how are you doing versus the regional benchmark, and if you're negative against the regional benchmark, then you're being kicked out of the program because the cost to the other providers is too much.

And so we've designed something that doesn't work for about half of the country. And the issue is, you know, not that our -- and we talk about these regional benchmarks and trends about rewarding efficient providers and punishing inefficient providers, but is efficiency really, you know, because I'm milking the system or am I inefficient because I serve the poor, right? And we all know about socioeconomic determinants of health, so the most expensive patients, the ones with the poorest quality, are going to be the ones that are mentally ill, that are underserved, that are minorities. I mean, it is the people

that we most need to help in this country.

And so I would just ask that in the final write-up that there's some indication, some guidance to CMS to consider these issues, because right now we have a crisis going on in the model, and nobody is talking about it. And if I seem a little upset, it's because nobody's talking about it.

Thank you.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you again for the great work here. I just had two small considerations. One is when laying out the goals for episodes I wondered if it would be worth adding something about how common a service is as one of the principles to be thinking about. Just that one seemed to be missing.

And then I think following up a little bit on one of Amol's final points about the zero-sum part of ACOs versus episodes, I've been thinking a lot about how to not double pay but how to actually create some incentives. And I wondered if something could be done around thinking about something like what percent of the population was referred to an episode provider that was efficient, or something

like that, where an ACO gets credit for having a larger percentage of their population go to an efficient episode provider so they get some form of reward for that because they're trying to do their part but not penalizing them if the episode doesn't go well or double-paying if it does.

Anyway, really excellent work, and I look forward to seeing this move forward in future sessions.

DR. CHERNEW: Can I just say a response to that comment? This came up a lot in our last episode discussion, this issue of sort of double-paying or not. And I think, you know, obviously time is going to be tight going forward, and Amol raised this point as well. The issue is that the obvious concern with double-paying is you're double-paying. The advantage of double-paying is it is conceivable that if you reward both for a given savings you actually have a bigger pie, and so you're losing -- for a given amount of savings you're paying too much but you're getting a bigger pie, so giving a little more is okay because you've induced everybody to save a bigger amount.

The extent to which that's true -- and again, the expert is sitting to your right -- the extent to which that's true is going to vary by the type of episode, it may

vary over time, and we have this difficulty in where we sit as to how we actually play that out. So we can go back and look at the language about exactly where it is, which I think is what Amol was suggesting, but in principle -- and again, for those listening at home, when CMS think about double-paying or not, the way this is supposed to be written, it is not sort of never double pay, that's a problem. It's not always double pay. That also could be a problem. It is considered, holistically, when you're doing this, how you're designing this, and again, that can differ across episodes and it can affect what episodes you decide to launch.

I said in other contexts, and if I haven't I'll say it again here, we're not CMMI, thank God, because I don't have the ability to run CMMI, get Liz doing it. But I do think giving them conceptual ways to think about this and how they integrate these things is what's going to matter.

And other part in what you said, which I think has come out -- and I do think it's in the chapter but I honestly can't remember different versions -- there's this question about whether the benchmark for the ACOs, ACOs

should get credit if they send someone to a lower -- an episode initiated with a lower benchmark. In general, we come out in favor of that approach, so that ACOs can save any savings they do just on the kind of process of care but also in directing towards a specialist, in particular ways.

That is complicated for a bunch of reasons, and we are not going to solve that in that we're not CMMI, but I think conceptually we would like to have the ACOs have incentives not just to practice officially in a range of ways they prevent episodes but also when there are episodes to think about where they go to capture some of that. The details are going to have to be sorted out by CMMI.

I don't want to have anyone at home think that we believe it is easy to do, because we don't. But I do think the principles here will help CMMI as they go, in particular, think about how things are coordinated and how the savings are divided, and understanding, as Amol said before, there is a possibility for synergies. It should not be ignored when making decisions.

But also, I would say, we have to be careful, they should also not be assumed. So you shouldn't assume that just automatically you could double-pay and it will be

fine. And I think it's just up to people that look at these in particular places. There are very, very capable people at CMMI to actually sort this out as they do it.

And so that's my loose take there. Sorry for the speech. I'll try and be better.

MS. KELLEY: Bruce.

MR. PYENSON: My compliments to the staff for putting this together. This is one of the more challenging things I've seen in my six years.

I've got comments on three topics. One is risk, the second is segmentation, and the third is trends. And each of these, I think, I'm not suggesting quantitative work but more nuance or suggestions of possibilities in the report.

On risk, I think many of the Commissioners recall the days when providers took risk and went out of business -- physician groups, parts of the country or other enterprises like that. And CMS, back, I think, in the 1990s, set criteria for risk for physician groups the requirement for stop loss and things like that.

What's interesting is none of the models we're talking about come anyplace close to that kind of risk.

But there are relatively rigorous structures for determining how much risk an organization should take, which is based on how much loss it can take without going out of business. Obviously, if hospitals went out business, physician groups, that would take away capacity from serving Medicare members, so that would be a concern.

So I think to put this in a realistic context of risk-taking ability would require reference to that, both the why we care, because we don't want organizations taking so much risk that it endangers their future solvency and ability to serve Medicare members, and maybe some references that, hey, there are things to look at, risk-based capital, there are a number of other solvency kinds of structure that could be used for that.

My interest in doing that is hopefully we will get to the point with ACOs where this is an important issue. We are no place close to that yet, but if the model evolves maybe that issue of risk hopefully will be important. So it's a real issue that needs to be dealt with.

The second issue is segmentation, and we did discuss, in other sessions, how the market gets split up,

for example, between low-income subsidy versus non-low-income subsidy with Part D or the enhanced plans or people who don't get Part D. And I think that's a concept that is important to think about because selection spirals happen all the time in insurance entities.

So since ACOs are voluntary and since there's another magnet, which is the Medicare Advantage, we have different segments of the market, and how trends are assigned -- you know, one of version of that is safety net versus non-safety net -- but the idea that perhaps the trends that get applied to an administratively-set benchmark should also consider the segmentation of populations into ACO participants and not, and what that might mean for the appropriate trends and the appropriateness of the program.

And my third point is we're actually in a pretty remarkable period with respect to the Medicare population. A million people have died from COVID. Most of them are Medicare beneficiaries, disproportionately distributed by race, ethnicity. Disproportionately distributed by afflicting people in nursing homes more than others. And that's a remarkable phenomenon that's going to affect the

program for the next 5 years, maybe 10 years, as well as the changes in the way people are getting their care and delivering their care.

So when we think about trends, I think recognizing that the unusual kind of period we're in, and we'll be entering in the next several years, that the usual way of calculating trends on a big program might not be quite right.

So those are three thoughts I have for the nuances in the writeup as we advise some of the readers. Thank you.

MS. KELLEY: Brian.

DR. DeBUSK: First, I'd like to thank the staff on an excellent chapter. It was a really good read. I'm very supportive, obviously, of APMs, and I'm really encouraged by our work on ACOs. Again, an excellent chapter.

I strongly support, obviously, streamlining the models. I think there is a lot of progress in this chapter, tailoring risk with the institution. I think moving to administrative benchmarks and addressing ratcheting, again, all good progress.

You know, I still remain concerned that ACOs don't have that overwhelming appeal or adoption yet, and one of the things that concerns me, you know, Amol had some comments around incentives, and my question is, do we have the incentives right, because things are moving so slowly. And it's easy to blame health care and just say, well, you know, health care moves slowly and these things take time. But let's look at things like in LTCHs, when we change the case criteria. You know, those LTCHs moved within a span of just a few years. When we make adjustments to the ESRD bundles, dialysis clinics change quickly.

And then my favorite example is telehealth. When the public health emergency hit, over a three-week period we went from virtually no telehealth visits to 1.4 million telehealth visits a week. We are in an industry that can turn on a dime when the incentives are correct.

And so I really want us to stress -- I mean, I hope we do some soul-searching here and realize we don't have those incentives right yet. Now I'm convinced we will get there. I think ACOs are the future. But I also think we need to take this as a sign that we really don't have the ACOs right yet.

That brings us to bundles, and I think it is very, very important that we keep bundles viable and we keep bundles growing. There is no question they engage specialists. There is no question they drive provider behavior, and they drive provider behavior in an era that we desperately need programs that drive provider behavior.

And I think it's important that we don't encumber one, and I do want to pick on two charts from the presentation, on Charts 11 and 12, where we talk about the considerations for bundles and episodes. I've said this before -- it feels a little bit like an obstacle course. And I could talk about all six points but I'm going to talk about three.

First of all, point 2, whether the episode could generate savings that the ACO could achieve on its own. Well, over 50 percent of physicians are employed now by hospitals. I mean, you could argue that for any bundle. I mean a joint replacement. Well, the hospital can simply hire the physician. You know, I'm not sure what test we're setting up there but it seems like an impossible obstacle because most of these could be addressed through physician employment.

Point 3, whether it will increase volume. You know, as we had in our discussion yesterday about social determinants of health and equity, not all volume increases are bad. I love that expression, there's no free lunches here. So I think that's another questionable criteria.

The other, and I acknowledge these aren't necessarily criteria. These are just guidelines. But the fourth one is whether the episode inclusion would discourage ACO participation. To me that just seems like a very intangible measure. I'm not sure how we're going to measure potential to discourage participation.

And that brings me to my final point, which is on double payment. Amol, I could not agree more with your concerns around double payment and this zero-sum mentality. First of all, I do hope the staff will quantify how much overlap has occurred. I would really be interested in, you know, here are the ACOs' net savings, here are the bundled payment net savings, here are the overlap. And I don't know that we have the information to have an exact calculation, but I would think that we could build a model to try to approximate some of that.

And then also for the short and medium term, I do

hope we advocate an all-of-the-above approach. I hope we do not encumber bundles. I hope we continue to build strong incentives for ACOs, because I think ideally, we would be in a world where we have a bottom-up program in episodes that are frontline driving provider behavior, and then a top-down program with ACOs, and we let those programs meet in the middle. And I think that's the optimal solution, not just for getting APMs up and running but ultimately for saving fee-for-service entirely.

Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. Two comments and then I just also wanted to emphasize again what Lynn said, which I think is important. If we talk about equity when we're doing SDOH work, but then we don't talk about it when we're doing work on ACOs and episodes, for example, we're kind of marginalizing it, I think. So even if the chapter does no more than flag the issue that Lynn was talking about, I think that would be worthwhile.

The two comments I had coming in today were, one is I think there's attention in the chapter between the fact that as we started the APM work the whole emphasis was

on having fewer models and harmonizing them. And so the ACO part still highlights, really, we want fewer ACO models.

But when we talk about episodes, and we may all not agree about whether this is solvable or not, but the clear impression that is on who reads this, especially people who read it quickly will be, well, we want a lot fewer ACO models, we want a lot more episode models. There are two or three places in the text where we talk about testing a wide variety of models, which testing a wide variety doesn't mean implementing a wide variety, but it kind of gives that impression, I think.

So I think regardless of one's point of view on this, the chapter will leave some people confused, I think. Are they saying there should be fewer ACO models and a lot more episode models, or what exactly are they saying? So some attempt to at least highlight that issue.

That would be my first point. And my second is what I talked about a little bit, I think, yesterday. I think it's not hard and fast for every type of possible episode, but in general I think it's easier to do episodes for surgical procedures than for medical chronic conditions. And I think we all here are pretty familiar

with the issues, but I think we have to take into account that there are a lot of people out there in the world who just think, oh, bundles are great and everything should be bundled. I'm talking about relatively unsophisticated on these issues.

And I've had pretty prominent people who I would've thought would be more subtle about this, literally say, "Why don't we just bundle everything?" And then there are people whose kind of life work is to argue that everything should be bundled. And not anybody in this room. Not at all. I basically agree with everything Amol said, maybe with a caveat, really what Mike was talking about, with the possible double bonuses.

So I think this is just a matter of tone and placement and just minor changes. We did talk about chronic conditions, we call them, as one of the six considerations, I think. And I would be happy if we just specified a little bit more explicitly it may be more difficult to do things for many chronic conditions, or I would say chronic medical conditions than for surgical episodes. It is not always the case. Glaucoma, for example, although it is, to some extent, a surgical

condition, you could call it a medical condition. I'd just like to see the wording changed and to point out that a lot of people with chronic conditions have a lot of chronic conditions.

And I would literally say it's very common for a person to have diabetes, congestive heart failure, COPD, arthritis, hyper-cholesterol, hypertension. Primary care physicians see many patients like that every day, and it's hard to bundle that kind of thing, in my opinion.

So I'd just like that called out a little bit more explicitly, and not just on page 26 or wherever but also just a sense or two in the executive summary would make me happy, just to deal with the fact that, basically to try to educate a little people who just think, gee, bundles are great. Let's bundle everything. We all know that's probably not desirable, but not everybody knows that. I think the report as written now could, to some extent, encourage that point of view still.

DR. CHERNEW: Can I just jump in and react? First of all, I think the juxtaposition between Brian's comments and your comment, Larry, was great. Because I think Brian read the chapter as, the chapter reads there

shouldn't be any episodes and we have to make sure that episodes are viable. And your comment was that the chapter reads like there's going to be too many episodes and we have to make sure that we're cautious where there are episodes.

But let me just try and say, at least my thinking, because we're not going to have a ton of time to change a lot of the wording. These comments are really helpful. We will go through it, and I think the staff will do their best. I will try and help you all get a chance to read it, but there are a lot of people's views in it. It's interesting that people read the same chapter and take away different senses of the tone.

That part being said, what the intent is, and for those watching at home, is we are actually not taking a position necessarily on whether there should be a lot or a few episodes, that there's a series of criteria, and the notion is given that you're going to have a foundational ACO or ACO-type model, think about when you add the episodes collectively.

But the part that I would say, if you think about episodes, is you have joints in BPCIA, you could have

joints in CJR, you could have a version if the hospital is participating, a version if a physician is participating, and then you could add, say, a post-acute bundle that might then influence the way in which you think the joint thing is happening. And I've heard people say they want a hospitalist version of it, so you would have a bundle for the hospitalist and a bundle for the surgeon in the same type of thing.

So the notion of fewer episodes in the episode context is almost, if you're going to have episodes in, let's say, lower extremity joint replacement, don't have five episodes in lower extremity joint replacement, and don't divide up the parts of it into different types of places. There might be details because that's going to differ across things, where CMS would change, but the advice to CMS is to think about how all of it works together, with the episodes and with the ACOs.

If they decide to move to more conditions -- I agree with your point, Larry, and the chapter was trying to be clear -- we do agree that chronic episodes are much more problematic, for a whole range of reasons. We can check the wording, but we didn't want to go so far as to say

never do chronic because there might be something. And although we think surgical episodes or procedural episodes might be valuable, there could be examples where they're not, for a bunch of reasons, because if you have a foundational ACO model -- and I realize not everybody is going to be in it -- but if you have it, you're giving all of the savings that you want to one set of providers and not another. And again, we're not telling CMMI how to deal with it, unfortunately. We're just saying you have to be considered.

I've had long conversations with Dana Safran -- who I will say, it's wonderful to see you, Dana -- about what they did in Massachusetts when they had the alternative quality contract and how they thought about adding episodes, where they were additive or not, in that context. And I will defer to Dana to say something about that. I think she's two-off in the queue.

But just so that everybody understand, at least my thinking, we are not saying have a lot of episodes or have few. We're saying think about when you do things how they all interact together, and many of the principles you raised I am completely down with.

DR. CASALINO: If I could just respond quickly, Mike, I think it might be useful just to have a sentence or two just saying we're not really arguing about how many -- we're not making a point about how many episodes there should be, just something along those lines, because right now I do think that readers could be confused: Wait, are they saying there shouldn't be very many episodes? Because they're talking about harmonizing and stripping down, you know, reducing -- or are they saying there should be a lot of episodes?

DR. CHERNEW: Yeah, actually let me just say one other point, which is something I've realized in this conversation. There's two related issues. One is, for how many conditions should there be episodes? And then within the conditions for which there's episodes, how many episodes should you actually have in those conditions? Because there's actually multiple episodes within the same condition in the way that the system works now, and other complexities. But I don't want to rant or belabor that point.

DR. CASALINO: All right. And just the last two things very quickly. One, just as a thought experiment for

Commissioners and, as you call them, the people at home, I would say would we be happy if we had three ACO models and 30 bundled models? I won't say any more about that, but just worth thinking about, I think.

And a somewhat related comment is that let's -- to kind of extend this as a thought experiment, let's say we had 30 surgical bundles, and that's kind of it, and ACOs. Basically then the surgeons can stay out of ACOs and do their bundles, and the primary care physicians, as always, will be left dealing with all the complicated messy stuff that takes a lot of work, that doesn't end after 30 days or 60 days or 90 days and is a lot harder to make money from than procedural specialists can make from bundles.

Again, I'm not saying this should be addressed in the report, either of the thought experiments I'm talking about, but I think it's worth thinking about at least.

DR. CHERNEW: Amol, I think, wants to get in on this point, but I think that is the tension in the comment that Brian made about this, and the real issue is going to be where there are synergies. Amol?

DR. NAVATHE: So, Larry, I like a lot of your

points, and I think there's a lot of validity to what you're saying. The point that I think is worth highlighting here is the way -- my understanding of where the Commission has moved over time -- this is not my view; this is a reflection of where I think the Commission is -- is we have articulated that we are starting with a foundational population health model. What that means, I think the commitment there is specifically saying that there's multiple ways to do value-based payments. One version of how we could do value-based payments could be entirely episode based, and you could just slice and dice all of Medicare care into episodes.

I think the point of articulating that we're going to use ACOs or population health models as a foundational model is specifically saying that's not what we're doing. We're pursuing population health as the foundation, and, therefore, episodes have to fit in with that. And I think your other points come from that or kind of are addressed in part downstream from that.

To the extent that we could make that clearer in the chapter, I think that would be great, because I think that would address your concern and also make it clearer

for everyone else.

In terms of episode choice, you highlighted that chronic conditions, surgical conditions, procedures, this, that, you know, health care is complicated. It's really hard to create binary designations and say this fits in an episode and this doesn't. And I think Paul, in fact, make comments last time that really opened my eyes to this idea that, well, there can be chronic conditions like glaucoma or MS and others where, in fact, we want to consider episodes because they may complement and we may not get those types of savings if we don't have those episodes in ACOs alone.

So I think this tactic that we've taken here of putting considerations and saying here are the considerations, and I think Consideration No. 1 to me read as it has to feel like it's episodic and not like a true kind of condition like diabetes where you have this recurrent cycle that is not -- you can't really have a starting point and a stopping point. That's really important to articulate that principle because I don't think we're going to have time to vet this dimension, that dimension, any kind of binary way as part of our MedPAC

work.

So I just wanted to make those two clarifications.

DR. CASALINO: I would just like to see that principle a little bit more explicit than it is right now, I think.

DR. CHERNEW: I just want to make sure we get through the queue, so I think if I'm right, Jonathan Jaffery is next and then Dana.

DR. PERLIN: Great. Thanks, Mike and everybody. I'll echo the kudos from the other Commissioners. This has been a fantastic chapter. Somebody said it was one of the -- Bruce commented that this is one of the more complicated you've seen in six years on the Commission, and it has taken two very complicated things and started to weave them together.

I think I'm going to -- I think this conversation makes it clear that we have come a lot further, I think, in understanding some of the problems around the population-based payments that we feel should go forward and that the bundles were still -- the episode payments, we're still working on a bit more. So I'm going to try and focus -- I

know there are others who are in line, and so I'm going to focus just on a few things about maybe thinking about for the future and laying the groundwork in each of the areas.

So to start with the population-based payments, there are two big points I want to bring back, and you've heard me say this before, but I think thinking about how we push organizations into different levels of risk, I would say that size doesn't automatically equal risk readiness. Brian made the comment about, you know, how some things turn on a dime and gave some few examples, and I think there's some good points about how our payment models have pushed things. I remember when erythropoiesis-stimulating agents were included in the ESRD bundle, and literally, just very, very quickly, we saw people starting to use iron more, and tremendous cost savings, better patient outcomes, lower cardiovascular risk. It was a great example. Telehealth also, we saw that move incredibly quickly.

But I would argue that the ESA example in dialysis is a pretty discrete piece. Telehealth, we basically did the same thing we've been doing for decades, and we use a technology tool that we all have gotten used to using in our everyday lives. And I think it's very

different than switching care models that are really important for lowering total cost of care and raising quality and coordinating care. And that's what we're doing with advanced primary care models and shifting care to the home and embedding social determinants of health. These other things may be tools for that, and, you know, having been in a big organization for a lot of years -- and some of my other colleagues here have been at academic centers as well -- we do a lot of great things. We're not necessarily known for being nimble. And so that's one thing on population-based payments to think about.

The other thing that we talked a lot about that I don't know comes out in the chapter as much that I think is a super-important issue is the convergence idea over time. I think that's critical. I think we need to really put a stake in the ground and be very clear and vocal about the fact that it's not okay that forever we're going to have providers -- or beneficiaries costing sometimes two or three times as much in some areas of the country as others for no reason related to those patients, but because of local practice patterns -- we know we can't shift that overnight, but we do want to have that over time. So I'd

like to see more emphasis going forward around the convergence question and just more prominence.

In terms of episode-based payments, I'll make three comments. One, you know, this notion that when somebody -- if a beneficiary is in an ACO and getting an episode, the ACO helps to mitigate some of the concerns about incentives for increased episode utilization. I think it's a really important issue. And I think it's related actually to some of this issue of who's incented for savings and double paying. The real opportunity for an ACO in many ways is to prevent the avoidable episodes. And then there's much greater savings, and they get to keep them all. And that actually gets to where, if we can -- if this gets structured right and people take advantage of it, our primary care practices and our ambulatory care practices can come together and actually reap the benefits of creating efficiencies. You know, they get to maintain some of the waste that they -- benefit from some of the waste that they get out of the system.

And I think an issue that came up I guess last month was the question of if somebody is in an episode, if it's not an avoidable episode, but they're in an ACO also,

how the ACO captures some of the savings inherently in the CMS discount that the episode provider gets. So it may not be CMS savings. Maybe there's a double -- maybe we can consider that double paying, but I think it benefits the ACO -- that discount may benefit the ACO.

Second of three points for episode-based payments, we talk about and in the presentation, you talk about providers and ACOs have an incentive to refer patients to low-cost providers. We've talked a lot about that. I would like to see us also think about incentives for referrals to high-quality providers, so there are other reasons to refer patients to specialists, and we shouldn't lose sight of the fact that sometimes the quality piece may trump the cost piece or be just as important.

And then, finally, to weigh in on this notion about chronic conditions versus surgical or procedural, I do -- and my thinking has really evolved a bit over the last day and I think really prompted by Paul's comments about glaucoma and Parkinson's and MS and things like that. And it's certainly true, I mean, what Larry described about the patient -- the hypothetical patient that he described with that list of conditions is basically my clinic.

That's what I do every day. And so the way I actually have thought about this -- and this may be something we try and think about in a principle, but -- and there's no good idea about how we would actually operationalize this at this point. But, you know, if a primary care provider is going to manage the condition, then it's not good for an episode. And if they're not -- whether it's chronic, a year, 90 days, whatever, acute, it may be, because it's very uncommon for a primary care provider to manage all their patients' glaucoma as an example; whereas, you know, they're going to manage a lot of the diabetes and a lot of the kidney disease. They may do it in collaboration with a specialist; they may not for all their patients. But there are criteria -- or there are things that they just won't manage.

So, again, it's been amazing to see this work evolve, and to try and weave in together these two really complicated things has been just masterful, so I appreciate all the hard work.

MS. KELLEY: Dana?

DR. SAFRAN: Yeah, thank you. I'll just add my very, very strong and heartfelt compliments to the team on

the evolution of this chapter. I think it's very strong, and the one thing that hasn't been said about it in people's opening comments is I think you really hit it exactly right in this version on how you synthesize what's known from the literature. I really like the way you differentiated what we know about population models from what we know about episode models, and my reading of your synthesis is it was spot-on. So I really appreciate that.

I do have some comments. None of them are things that would require any kind of substantive change to the work. One or two might be things to think about for the future or, you know, a couple of small changes before we go to press.

So I'll start with three overarching points, and two of those pick up on comments that we've talked about. The point was made earlier about, you know, admin benchmark for the population models but not for the episode models. I think there are some key differences in what we're recommending for the two models, and it might be useful up front to call that out and say why we did that. So the benchmarks are one. The voluntary versus mandatory is another. I think that would serve us well to call those

out.

The second overarching point relates to the question Stacie asked at the opening, and we had some discussion about it, and Lynn's passionate remarks. You know, I think that having something in the opening about the importance of addressing equity and, you know, if folks are comfortable, I would be comfortable calling out what was done in the REACH model with respect to benchmarks, not to say that that is the right adjuster, right? The area deprivation index in fact may not at all be the right adjuster, but the right idea to be adjusting the benchmark for socioeconomic and social drivers of health that we would really urge CMS to consider incorporating that as a core feature and to keep improving learning what makes for a good adjuster and incorporating that.

It could be that using proxy data from the area level just isn't going to get the job done, but that, you know, something like duals, which is person-specific, is too narrow. So we may need the best of both, you know, which has data collection implications that are not trivial. That may have come up yesterday, and I apologize that I wasn't here then.

The third overarching point is around quality incentives. That started to come up a little bit. I'm just struck -- and this is probably not for this chapter, but for us to think about going forward. You know, I spent some time thinking about the synthesis of the literature and done a little bit on my own, and I'm really struck that the Medicare models have not moved the dial very much on quality. And in contrast to, you know, the model I had the privilege to help design and then lead at Blue Cross, the Alternative Quality Contract, where we saw really significant changes in quality and even in health outcome indicators, the few that we had for ambulatory care for chronic conditions. And, you know, what difference -- you know, there's some differences, but probably the biggest difference that drove that is we put an awful lot of money on the table for the quality incentives. And I'm not saying that's the right thing to do, but I am saying that that's the one difference that is clear to me between that program and the various portfolio of Medicare programs. And so at whatever point you feel like we have quality measures that, A, are strong enough and, B, are in need of improvement enough, we should consider putting more

significant dollars behind the quality incentives, because I think the way we structured it in these programs is just not moving the dial.

Okay. A couple comments about population and then a couple about episodes, then I'll finish.

So on population models, I do think it would be helpful to make a comment -- I think this came up earlier -- about what impact we think the shift post-2025 in fee-for-service rates for A-APM participants versus nonparticipants is going to have in ACO participation. You made a really important point in the opening and responding to that about, you know, MIPS and the generosity there, and that was a new factor for me to start thinking about. But I think just saying something about what we expect post-2025, if anything, for those incentives to do in terms of driving voluntary participation, since we're recommending population-based models be voluntary, would be a valuable addition.

The second point is that I really like that we landed on the three tracks. I know I said last time and I'll say again I don't favor the idea of a single track with varying risk based on things like revenue or other

things, because I think it is just to game-able. I think we've seen that in some of our other work, including in Medicare Advantage, you know, of the breaking apart and bringing together of contract units. And so I just think the three-track model feels stronger to me.

My one beef with it, if I could call it that, is it's very light on details right now, and I know that was probably intentional. But I do think we have to say something about the importance of paying attention to adequate sample size as the risk levels go up, and even adequate sample size to participate in the Level 1, because we don't want -- since it's upside only, we don't want Medicare paying shared savings based on complete noise. So I think we have to say something there about sample size.

And then, finally, on that, I'll just say I'm really excited about the benchmarking recommendation and really hopeful that that idea will take hold.

On episodes, I think I just had one or two comments to make. I really like where we landed on mandatory participation for bundles, and I think that, as I've thought about, I really love how it could impact ACO participation and ACO success. So I like that very, very

much.

The one thing that we didn't address that I think is worth considering, especially given the comments about, you know, how do we begin to build over time more episodes into the portfolio of programs that Medicare runs is how we think offering episodes is going to impact the composition of ACOs. So will it drive consolidation? Will it drive de-consolidation? What might it do that feels like something valuable to contemplate? And maybe just say a few words about it.

So those are my comments. Again, thank you for this work. I think this is a really important chapter and hopefully will really be one that has some impact and influence. So thanks very much.

DR. CHERNEW: So just for those at home, we have four more people in the queue. We are at time. This discussion has been really rich, so I think we're going to just keep -- I want to make sure -- please be brief. I will try. But let's just continue the discussion for the folks in the queue. We're not going to have a third round or broader comments. I'm sure you all have many. Send them to meetings@medpac.gov.

In any case, I think the next person in the queue, if I have this right, is Betty. Is that right, Dana? Oh, I take it back. It was David. It was David, then Betty. Is that right?

DR. GRABOWSKI: All right. Great, thanks. First of all, thanks to the staff. This is super work, great discussion today.

To Mike's earlier point, I can't remember a chapter coming this far from the start of a cycle to the end of the cycle, so really, really impressive.

Let me start by saying I am very supportive of this work. It takes, as Jonathan said earlier, very complicated topics and puts them together. But the basic framework and the architecture here is sound. So I'm very supportive.

I wanted to make two points. One is about framing -- it's more conceptual -- and the second is kind of maybe work for the future.

So the framing work, the chapter reminded me a little bit of a professor I had in grad school, very beloved, great teacher. But whenever you asked him a question he would launch into the middle of his answer, and

we said he had sort of "first sentence disease." And I think this chapter suffers a little bit from first sentence disease in that there's no kind of setup here, and like what's the problem we're trying to solve? And we sort of refer back to these earlier chapters, but I didn't feel like the chapter was very self-contained.

So is there an opportunity to say what are we trying to solve? What are the principles up front, rather than jumping into the ACO principles and jumping into the episode principles? Is there an overarching framework? I think the chapter would be much stronger if we did that up front, and kind of that background. We sort of get into the specific models very, very quickly. Let's give an overarching framework here. So that's kind of a conceptual point.

My second point, and this won't surprise you, I thought a lot in reading this about the duals. We have these totally separate models for dually eligible beneficiary -- Pat obviously knows a lot about these and runs them -- whether it's the D-SNPs, the FIDE SNPs, the financial alignment initiative, PACE. All of these models are sort of separate. I don't think they belong in this

kind of chapter, but I just wanted to orient us that we have these high-risk, vulnerable beneficiaries. Are they being well served by these models? I know we have peer groupings and I know they're in these models, but how do we think about kind of the duals, vis-à-vis this existing framework?

I'll stop there. Thanks.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you very much. I will be very brief, I hope. I really appreciated the chapter and really have enjoyed the conversation. I'm going to focus just on a couple of points. I think I was one of the champions of the bundles for chronic conditions, and I would just like to talk a little bit about that.

I hear very clearly what Larry and Jonathan have said about people not having just diabetes or just dementia, or whatever, and it's because of that complex interaction of needs that I really hope we can continue to think about how we have fresh approaches to chronic condition management, this cascade of interacting factors.

And you all know the silos, that payment silos create treatment silos, the polypharmacy, the cascade of

low-value care, but I'm also very, very concerned about the suffering that the health care system itself creates at the working surface, as people try to manage their lives and deal with all this episodic care.

So I understand that it's not episodic. It's interacting bundles of need. And it's too difficult in terms of risk adjustment. Different time horizons would be needed. And that's why I continue to support mandatory population-based approaches or, as Amol and Brian have said, and I think Jonathan has said, stronger incentives. So I'm very comfortable with thinking about the stronger sentence.

And then continuing to think about, you know, John Rawls' thought experiment. If we didn't know who we were in society, how would we want this set up? And it certainly wouldn't have a lot of the elements it currently has.

I was very taken by Paul's notion of these product conditions that really are at the episodic sort of -- you know, they have a beginning and end, which goes with Slide 11, Number 1, so I strongly support that.

And, Jonathan, your comments about things primary

care shouldn't take care of I think is well taken, but there are also things that we should be taking care of that we refer to specialists, because it's easier and we would have to have so much volume, whatever.

So those are the things I'm thinking about.

So finally, voicing support for Amol's idea of not making these things be opposing but interacting and supportive. Thank you.

MS. KELLEY: Jaewon.

DR. RYU: Yeah, just a few additional comments. I'm also a big fan. I think the episodes and population-based models are the right tools. They should work together. Between the two I do think the base, kind of as Amol described or characterized where we are as a Commission, I think the base model, if you will, should be a population-based model. But within that I do think episodes still play a role.

I still worry, though, about how the two interplay. I have concerns about how the pie gets split. I think the more you slice up the pie, the pie becomes less appealing overall. And so I think we still need to think through how that interacts, because I think it also

diminishes the incentive for those in the population-based models to make the right investments to really transform the care model.

I think partly this gets to, of the six considerations the one on Slide 11, number 3. You know, concerns about episodes and whether the model will increase the volume of episodes. I think that's where I have my deepest concern. I think Jonathan used the term, you know, "the avoidable episodes." I think part of this, we may want to give some more mention or thought or recommend, the triggering event, I think, is a key piece of this, and who is in a position to actually make an impactful decision at that triggering event moment?

I think episodes lend themselves naturally to situations where it's more cut and dry whether the episode triggers. I think where there's wide variation in terms of whether an episode triggers or not, I don't think that's the right place to use an episode, because I think you're going to get more utilization than maybe needs to be there. And so I'd love to see a little more fleshing out of some of those concepts.

I think that's it. Thank you.

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Thank you. I'm really pleased that my colleagues brought up the thoughts I had about chronic disease episodes. And, you know, I think the key is that what might make a good chronic disease episode is not particularly correlated with other chronic conditions and really where the management has done. There's not much involving of primary care, so the coordination isn't a point, and I think there's a lot of potential of very successful episodes.

I want to raise a point. You know, we've talked on and off about participation, and really focusing on participation of specialists, depending on how the episode payment rewards are given, whether to the specialist provider or the ACO. And I started thinking about, you know, do we really even need specialists to be members of ACOs, and maybe it would be better if ACO membership was primary care only. There's a lot of steering of patients to efficient, high-quality specialists, and that's what primary care physicians would do. It probably wouldn't be a bad idea if very efficient, high-quality specialists were affiliated with multiple ACOs rather than choosing one, so

that all the ACOs in the community that perceive the advantage of that when referring to that specialist.

So anyway, this isn't something we can resolve for this June report, but something to think about for the future, and particularly relevant to how much we should be concerned about specialist participation.

The final thing I want to say is that there are two audiences for this chapter. In the short term, as Mike mentioned, CMMI. I think there's a lot of potential for them to be influenced and benefit from what we're talking about in this chapter. But, you know, the model we're setting out is going to need legislation to really become effective. So we need to always keep in mind that Congress is an audience for this chapter as well, even though we don't have recommendations at this point. But we certainly do have a whole concept and a strategy, and hopefully people will start thinking about what a better model for ACOs and episode payments can be in the future, and there will be legislation needed to get us there.

DR. CHERNEW: I think Pat wanted one very quick thing, and Pat, you are going to have the last comment.

MS. WANG: Thank you. I don't think it's for

this chapter, but again, for future consideration. One of the things that struck me in reading the work, which I agree was excellent, was that it didn't express a point of view which way we would encourage CMMI to lean. It was very carefully constructed about the recommendations on ACOs, this is what to do with episodes, and potential ways to help them sort of blend with each other.

But there's not really a point of view in there of which way the Commission thinks these APMs should lean, and I think based on the discussion today it's mixed, but my perspective is that if push came to shove it should lean in the direction of population health.

I think that the episodes are fabulous and that they are advancing the way that certain care, which is amenable to start-and-finish and a bundle and basically just almost like a new concept to the DRG, for example, to pay for a joint replacement, which is maybe where this should ultimately go, they're great. But that at the end of the day what's really needed to achieve the goals that people have described is to give more resources to primary care doctors, because they are doing the heavy lifting for the real things that people need in their lives, over time,

and incentives for specialists to coordinate with primary care doctors, and to see those referrals quickly, to get back to the PCP.

There are other things going on with advanced primary care models but it might be an area of additional attention in future work on ACOs. Thanks.

DR. CHERNEW: So thank you, Pat. A, we're going to skip our break because we're a little bit behind. B, I'm going to summarize.

It's interesting. Brian thought it said not enough episodes, Larry thought it said too many episodes, and Pat thought it didn't particularly take a view.

[Laughter.]

DR. CHERNEW: So we're great. But I will say this. Here's my summary. We have a foundational population-based payment model, which I think we understand what that was, and there was actually, I think, a lot of support for how that was laid out.

Here's my summary of how episodes should be thought through, and again, we don't have time to debate this, is add episodes when they grow the pie more than they slice the pie. So there are opportunities to grow the pie

with episodes, and when that's true we should add them. And we should just be aware that when we do that there is also a slicing effect, per Jaewon's point, and that's going to be different in all different conditions.

So this chapter is much more about how CMS should think about balancing the growing of the pie and the slicing of the pie effects, and we'll just have to see where that plays out. If it's 300 episodes, as Brian might think, or 3 as someone else might think, that depends on CMMI or CMS analysis. We aren't taking a particularly hard and fast view, but within the episodes we want them to be harmonized.

That was even longer than I thought.

Anyway, thank you, guys. I think the other thing that was really a consensus is how good a job you did and how much support there was for the basic structure. Time is going to be super tight, for every who knows, to get this out, but I think we will do what we can, as best we can, given these comments.

So again, thank you. We're going to switch on to site neutral. We're going to skip our break. But if some of you, like me, need to take a break, I'm going to have to

step out for a second.

DR. MATHEWS: Whenever you are ready, Dan.

DR. ZABINSKI: Okay. The audience can download a PDF version of the slides for this presentation in the Handout section of the control panel on the right side of the screen.

From 2012 to 2014, the Commission evaluated the effects of aligning payment rates for services provided in hospital outpatient departments with payment rates for services provided in physician offices, and at the November 2021 meeting, we presented an analysis that built on the Commission's previous work. Today, we will revisit the November 2021 presentation, with some modifications.

In response to requests from Commissioners, we added an assessment of whether adjustments for patient acuity are needed when aligning payment rates across ambulatory settings. We also modified our method for identifying services for which it is appropriate to align payment rates to include volume data from 2016 through 2019 rather than just 2019 alone.

Fee-for-service Medicare has distinct payment systems for three ambulatory settings: physician offices,

hospitals outpatient departments, or HOPDs, and ambulatory surgical centers, or ASCs. Payment rates often differ for the same service among these three settings, and in particular, the outpatient prospective payment system, or OPPS, which is the payment system for most HOPD services, has higher payment rates than the physician fee schedule and the ASC payment system for most services.

The primary concern about these differences in payment rates among ambulatory settings is that they result in providers in higher-cost settings acquiring providers in lower-cost settings than billing at the higher rates. For example, hospitals can consolidate with physician practices and convert them to provider-based departments. Hospitals can then bill for the physician services at the usually higher OPPS rates with little or no change in the site of care.

In recent years, hospital acquisition of physician practices has led to an increase in the share of office visits, echocardiography services, cardiac imaging services, and chemotherapy administration provided in HOPDs with an analogous decrease in the share provided in physician offices. This shift of services increased

Medicare program outlays and beneficiaries' cost sharing liabilities.

The Congress passed the Bipartisan Budget Act of 2015 to more closely align OPPS payment rates with PFS rates, but the effect of this policy has been limited, as services affected by this policy constitute less than 1 percent of total OPPS spending.

On this table, we show how hospital acquisition of physician practices has led to the billing of two important services shifting from offices to HOPDs. From 2012 to 2019, the share of office visits provided in HOPDs increased from 9.6 percent to 13.1 percent and the share of chemotherapy administration services increased from 35.2 percent to 50.9 percent. Note that these are just a subset of the services that have shifted from freestanding offices to HOPDs. And finally, this shift of services illustrates the need to align payment rates across settings.

It would be easy to align all OPPS and ASC payment rates to the physician fee schedule payment rates and say we're done with payment alignment. However, these sites of care have important differences that we must consider. One is that some services that are provided in

HOPDs cannot be provided in offices or ASCs because they are not covered under the physician fee schedule or the ASC system. The most obvious of these are ED visits, but there is also relatively complex services such as some joint replacement procedures that are covered under only the OPPS, and these services must continue to be paid at standard OPPS rates.

Another issue is that the OPPS and the ASC system have more packaging of ancillary items in their payment units than does the physician fee schedule. We must account for this additional packaging when aligning payment rates. Also, we should align payments across settings only if it is safe and reasonable to provide the service in lower cost settings for most beneficiaries.

At the November meeting, Brian and Paul expressed an interest in an analysis of the relationship between patient severity and patient costliness. This relationship is a concern because if sicker patients do increase the cost of providing a service, an effective payment alignment policy would include adjustments for patient severity.

We did a regression analysis that estimated the effect of patient health status on costs for services for

which we aligned payment rates across ambulatory settings. In these regressions, we used the dependent variable that was the beneficiary-level charges from HOPD claims for the services combined with the charges for packaged ancillary items to create charges for payment bundles that would occur under the OPPS. The explanatory variables that we used are an identifier for the hospital providing the service, an indicator for whether the beneficiary had full Medicaid benefits, the beneficiary's sex, and the beneficiary's Charlson comorbidity index, or CCI, which is a measure of the beneficiary's health status.

We found that the relationship between the beneficiary CCI and the level of charges was weak. For example, among the services evaluated, a 10 percent increase in a beneficiary's CCI increased charges by less than 1 percent. From these results, we conclude that in general, adjustments for patient severity are not needed for an effective system of aligning payment rates in the ambulatory settings. However, CMS should monitor whether there are specific APCs for which patient severity adjustments may be necessary as practice patterns change in response to site-neutral payments.

We went on to identify the services for which it is reasonable to align payment rates across settings by collecting services into ambulatory payment classifications, or APCs, which is the payment classification system in the OPPS. APCs are collections of services that have similar cost and clinical attributes, and all services in the same APC have the same payment rate.

In response to a request from Stacie, for each APC, we determined the volume from 2016 through 2019, rather than 2019 alone, in each of the ambulatory settings. We found that physician offices had the highest volume in an APC in any year from 2016 through 2019, we aligned OPPS and ASC rates with physician fee schedule rates using the difference between the physician fee schedule nonfacility and facility practice expenses, with an addition for the greater packaging under the OPPS and ASC payment system.

We found if ASCs had the highest volume, we aligned the OPPS payment rates with the ASC payment rates, but we kept the PFS rates the same. Finally, if HOPDs had the highest volume for an APC, we did not believe it was reasonable to align payment rates for that APC, so payment

rates were unchanged in each of the ambulatory settings.

On this slide, we have an example of why Medicare payments are usually higher when a service is provided in an HOPD than in an office and how we aligned the payment rates across these settings. The service in this example is a level 2 nerve injection.

In the first column we show the payments that Medicare makes if the service is provided in an office, the middle column shows the payments if the service is provided in an HOPD, and the third column shows the payments if we adjust OPPS payments so that the total payment in the HOPD aligns with the total payment in the office.

You can see that in all three columns there are three payments to the physician under the physician fee schedule: the physician's work, practice expense, or PE, and the professional liability insurance, or PLI. The payments for work and PLI are the same in all three columns. However, the PE is higher in the office than in the HOPD, making the payment to the physician higher in the office than in the HOPD. But there's an additional payment under the OPPS when the service is provided in an HOPD. For most ambulatory services, that additional payment under

the OPPS is greater than the difference between the nonfacility PE and the facility PE, which makes the service more costly to Medicare and beneficiaries when provided in the HOPD. In this case, the middle column shows that total payment is about $701 when provided in an HOPD, while the first column shows the total payment is lower, at $256 when provided in an office.

In the third column we adjusted the OPPS payment so that the total payment is equal across these two settings by setting the OPPS payment equal to the difference between the nonfacility PE from the first column and the facility PE in the second column, which results in an OPPS payment of $154.

In the third column, when we add the $154 to the $32 facility PE, we get a total payment for the facility of $186, which is the same as the nonfacility PE in the first column. So, when you add the payments in the third column, the total payment for providing this service in an HOPD becomes $256, which is the same as the total when the service is provided in an office, as indicated in the first column.

We went on to use this concept of the difference

between the nonfacility PE and the facility PE as the basis for aligning payment rates across the three ambulatory settings.

We know that the OPPS has 169 APCs for services. Using the methods that we've discussed; we've determined that it is reasonable to align the payment rates for 68 of those service APCs. We identified 57 APCs for which we aligned OPPS and ASC rates with the physician fee schedule rates. These APCs constitute 22 percent of the total spending under the OPPS and 11 percent of the total spending under the ASC system, and note that most of these APCs are low-complexity services such as office visits.

We also identified 11 APCs for which we aligned OPPS rates with ASC rates, and these APCs constitute about 4 percent of the total spending under the OPPS. And finally, we did not align payment rates for the remaining 101 service APCs.

For the 57 APCs for which we more closely aligned the OPPS and ASC payment rates with the physician fee schedule rates, beneficiary cost sharing and program outlays would be lower. Under the OPPS, cost sharing would decrease by $1.4 billion and program outlays would decline

by $5.5 billion. Under the ASC payment system, cost sharing would decrease by $60 million and program outlays would be lower by $230 million.

I want to make you aware that under current law, CMS would respond to the lower program spending and cost sharing with a budget neutrality adjustment to the OPPS payment rates for the APCs for which we have not aligned payment rates to fully offset the lower program outlays and beneficiary cost sharing from payment alignment. However, an alternative is that we could encourage the Congress to act so that the lower spending could be used as savings for Medicare and beneficiaries.

For the 11 APCs for which we aligned OPPS payment rates with ASC payment rates, all represent surgical procedures, including ophthalmologic, GI, and musculoskeletal procedures.

Aligning the OPPS payment rates for these APCs would reduce cost sharing by $260 million and program outlays by $1.1 billion.

Once again, under current law CMS would respond to the lower cost sharing and program spending by applying a budget neutral adjustment to the OPPS payment rates of

the APCs for which we have not aligned payment rates.

Also, a concern we have about aligning OPPS payment rates with ASC rates is that rural areas and some states have few ASCs, and if hospitals would respond to the lower ASC payment rates for these 11 APCs by reducing the provision of these services, that could lead to access problems in areas that have few ASCs.

On this table we show the percent change in total Medicare revenue for various hospital categories from the two payment alignment policies that we've presented coupled with the current law budget neutrality adjustments that CMS would implement. By definition, the net effect on total Medicare revenue for all hospitals would be zero, as indicated in the top row. Rural hospitals would have a decrease in total revenue of 2.3 percent while urban hospitals would experience a revenue increase of 0.2 percent. Also, government hospitals would have a total revenue decrease of 0.9 percent, while nonprofit and for-profit hospitals would have little or no change in total revenue.

The Commission has long been concerned about ensuring access to care for vulnerable populations. As

you'll see on the next slide, the payment alignment policies, without the budget neutrality adjustment, would reduce total Medicare revenue by a disproportionately high rate for some hospitals that serve a high share of vulnerable beneficiaries. So if the Commission has an interest in targeting some of the savings from the payment alignment policies to safety-net hospitals, we considered a temporary stop-loss policy that would accomplish that goal. We used DSH percentage to identify hospitals that serve vulnerable populations. The stop-loss policy that we evaluated would limit the loss from the two payment rate alignment policies that we discussed to 4.1 percent of total Medicare revenue if the hospital had a DSH percentage above the median DSH level of 28.1 percent.

On this table, the first column shows the combined effects of both the payment alignment policies without any budget neutrality adjustment for several hospital categories. These are the effects that would occur if we simply want to use the payment alignment policies to reduce beneficiary cost sharing and program outlays.

We found that rural hospitals would have a decrease in total Medicare revenue of 6.9 percent, while

urban hospitals would have a smaller decrease of 3.8 percent. In addition, nonprofit and government hospitals would both have larger decreases in total Medicare revenue than for-profit hospitals.

The second column shows the effects of adding the temporary stop-loss policy discussed on the previous slide.

Rural hospitals would still have a larger decrease in total revenue than urban hospitals, but the difference in revenue loss between urban and rural hospitals would be smaller with the stop-loss policy than without it. Also, the difference in revenue loss between nonprofit and government hospitals versus for-profit hospitals would be smaller with the stop-loss than without it.

We've shown that the potential impacts of aligning payment rates across ambulatory settings are substantial. With that in mind, it's important to remember the purposes of this analysis. One is that we want to address the principle that Medicare and beneficiaries should not pay more than necessary for ambulatory services. Second, we want to reduce incentives for providers to consolidate, which typically leads to the billing of

services shifting from lower-cost settings to higher-cost settings.

We also want to make it clear that the pool of money from aligning payment rates does not have to be used to reduce program spending. Possible alternatives include using the funds to increase the OPPS payment rates for the 101 APCs for which we would not align payments, which include services such as ED visits and complex surgical procedures. Doing this would help hospitals maintain standby capacity. Alternatively, the funds could be used for temporary policies to support safety-net providers.

So again, we intend for this analysis to be a chapter in the June 2022 report to the Congress. For today's discussion we will address Commissioner questions and comments about the analysis. And for future analysis, we are wondering about what should be done with savings from aligning payment rates. Should they be used in a budget-neutral adjustment required by current law or entirely taken as savings, or finally, in a stop-loss policy to temporarily support safety-net providers?

That concludes the presentation and I turn it to Mike for discussion.

DR. CHERNEW: Dan, thank you so much. I think we were doing site-neutral work back when I was on the Commission around 2010.

So, Dana, I have Bruce in the Round 1 queue, and I think that's all I have in the Round 1 queue. So Bruce, you get to ask a clarifying question, remember, as it was clear to everybody else. Go on.

MR. PYENSON: So if you go to Slide 15, Dan, a question. The percentage change is characterized as total Medicare revenue. That's inpatient plus outpatient revenue?

DR. ZABINSKI: Yeah. It's the whole ball. Everything that's received from Medicare. We'll call it total revenue, overall Medicare revenue in the payment update analyses.

MR. PYENSON: Now that's 11 APCs?

DR. ZABINSKI: No. This is 68 APCs.

MR. PYENSON: Sixty-eight APCs. Okay. Thanks. So hospital outpatient is a little less than half of Medicare hospital spending, right?

DR. ZABINSKI: It's somewhere in the, like 30 -- we'll say a third, in that neighborhood.

MR. PYENSON: So the impact on hospital outpatient is roughly three times these figures.

DR. ZABINSKI: That's right.

MR. PYENSON: Thanks. There is a comment about CAPCs in the text. What are those?

DR. ZABINSKI: Oh, CAPCs? Comprehensive APCs?

MR. PYENSON: Yeah.

DR. ZABINSKI: They're a baby step in the OPPS in the direction of sort of a more comprehensive payment bundle. They're typically complex procedures plus observation care. Basically everything on a claim gets packaged into a single bundle. That was a step towards more comprehensive payment bundles. They were introduced in 2015. The OPPS is still a somewhat granular system, but it got a little more comprehensive with these CAPCs. Like you go in for a pacemaker insertion, and instead of having some of the minor stuff paid separately, let's take everything and put it one single payment unit.

MR. PYENSON: My colleague does some work on emergency department, maybe two years ago, on the five levels, but that's all outside. The ED wouldn't be affected by this?

DR. ZABINSKI: No.

MR. PYENSON: So, let's see. One of the comments, for the discussion items, was there's 11 APCs that you raised the concern that some hospitals might try to avoid or reduce capacity, not the 68.

DR. ZABINSKI: Well, think of the 68 in two packages. There's 57. That's obviously the big packages, and the big things that includes office visits. Those are APCs for which we've determined that it's appropriate to align the ASC and the OPPS payment rates with the physician fee schedule rates. And then there's 11 more APCs that are strictly minor outpatient surgical procedures that we think it's appropriate to align the OPPS payment rates with the ASC payment rates. And those are the ones that we raised a concern about, in terms of, you know, if hospitals, in a response to the lower payment rates, would reduce their provision of those services, and that could potentially cause a problem in areas that have very few ASCs, in particular rural areas. There's just a dearth of ASCs in those areas, typically.

MR. PYENSON: Is there any evidence that hospitals have behaved that way in the past when particular

fees were cut?

DR. ZABINSKI: Not that I'm aware of, but that doesn't mean that it didn't happen. I'm not aware of it.

MR. PYENSON: Okay. Thank you. And could you explain a little bit why this is subject to subject neutrality?

DR. ZABINSKI: It's in law. It gets complicated. But the base thing is Section 1833T-something of the Social Security Act describes all the OPPS rules and regulations. And in there, basically anything where you have changed the relative weights in the OPPS there has to be a budget-neutral adjustment. It can be up or down, depending upon how they change. But in this case a lot of them would be going down. So what happens, by law, CMS is required to increase the relevant weights of everything else that wasn't adjusted.

One thing, a big thing, in fact, that CMS went against the grain on that is with, a few years ago they and the provider-based departments, every office visit in a provider-based department of a hospital is paid at OPPS payment rates that had been aligned with the physician fee schedule rates. I think it's finally been decided in the

courts, but there was a long, protracted court argument on that. But that's the only time I can think of where CMS went against what the current law says.

There was a small provision later in 1833T of the Social Security Act that gives CMS a little leeway on it, but it's kind of a big provision.

MR. PYENSON: Thank you.

MS. KELLEY: Pat. Did you have a --

MS. WANG: I did. Thank you. I was wondering, I'm trying to understand a little bit more about the estimate on Slide 11 of cost sharing savings and reductions. The exercise that you did here seems to affect clinic services, primarily. That's a very, very big chunk of the services that would be aligned.

And I'm just curious, of these cost sharing amounts, is it possible to know, for example, what sort of share of those services was consumed by dual eligibles for which the Medicaid program would, in fact, be the person paying, or the party paying the cost sharing? And the reason that I ask is that, you know, because of the way that the law is written, Medicaid programs often are capped in the amount that they will pay in cost sharing, being

limited to the amount that the Medicaid program itself would have paid. I think that in many cases that actually results in zero payment to the hospital because the cost of the Medicare service is greater than what Medicaid itself would have paid, so Medicaid does not fill in the gap.

So I'm just wondering, you know, because it's a very important consideration, right, beneficiary impact through higher cost sharing when the rates are not aligned. And I guess I'm just sort of poking a little bit to find out if that number is really being borne by beneficiaries or anybody, for that matter, especially for duals. Do you know what I'm asking, Dan? It's sort of a convoluted question?

DR. ZABINSKI: Well, offhand I believe, yeah, we could find out how much of that is related to dual eligibles.

MS. WANG: Yeah. And then it would have to be some presumption of how much these individual state Medicaid programs actually are paying for that cost sharing, because I suspect that in many instances they're not.

DR. ZABINSKI: I would say this. Identifying the

beneficiaries is not terribly difficult. Identifying how much, in dollar terms, is, I don't want to say impossible, but it gets close to that. I don't know. It's very difficult. How about that?

MS. WANG: Thank you.

DR. CHERNEW: Dana Safran, I think, has a Round 1 question.

DR. SAFRAN: Yeah, sorry. My chat function thing isn't working so I appreciate being called on.

I have a question about the information that's on Slide 9. I was trying to understand, for the OPPS payment that's listed there of $598.81, versus the $31.71 that they're paid for practice expense, what is intended to be captured in the $598 as opposed to the practice expense?

DR. ZABINSKI: The $598 is strictly for the hospital. That's the resources that the hospital expends. And the past expense is the physician practice expense.

DR. SAFRAN: Within the hospital.

DR. ZABINSKI: Within the hospital.

DR. SAFRAN: Got it. Okay. Thank you.

DR. CHERNEW: So now I think we're on to Round 2.

MS. KELLEY: Yes, and Brian is first.

DR. DeBUSK: First of all, thank you. I thought it was an excellent chapter. I'm wildly supportive of the work.

First of all, I want to give you credit for the criteria you used and the procedures you chose. I mean, I guess it's your job to do that, but that was a really good criteria. And when you look in the appendix at the APCs you chose, they are minor, non-controversial APCs. I mean, Level 1 skin procedures and things. So excellent. Excellent choice.

The one observation is even with that conservative criteria there's still $8 billion worth of savings, program savings, here, and it's a real testament to just how much unaddressed inefficiency in payment is in original Medicare. It's alarming.

Second of all, your methodology, I thought, was really, really excellent. I think the way you got to the base payment using the difference between the nonfacility PE and the facility PE I think is very clever. I loved how you grossed up the zero-day globals. I loved how you also packaged, or reverted to the nonfacility fee rate for the 90 days. So again, I think the methodology there was

great.

I also appreciate the work that you did on the acuity adjustment. You used HCCs. You used CMI. And, by the way, I liked your rationale too.

There are four moving parts here, though, when we talk about acuity adjustment, and you clearly won Round 1, by the way, both in methodology and in rationale. But ASCs aren't uniformly distributed by geography, and so it's going to be difficult working with Medicare claims, just because of the differences in their distribution, and also their capabilities differ. I mean, some can only do colonoscopies and cataracts. You know, I live 13 minutes away from an ASC that did 1,100 joint replacements last year, and this was an ASC that was doing that.

And then I think the other issue is the fact that original Medicare only pays about 52 cents on the dollar to an ASC. Well that creates a shift. I mean, there are probably some ASC-eligible beneficiaries who aren't going to ASC simply because they need to be shifted to hospitals to get the higher rate.

And the reason I say this is if you do try to do some of the acuity adjustment work that you did, with all

these moving parts, what you're going to get is a regression toward the mean, and you're going to get the answer that you received, which is, well, I don't think it really matters, because we see some high acuity, we see some low acuity in the analysis.

But fortunately I think there's a solution here -- Medicare Advantage encounter data. You know, the data was terrible a few years ago, but from my understanding it's getting better and better. What would be fascinating is to do a similar -- first of all, I would include a dichotomous variable or some proxy for ASC availability, and I don't think you can measure ASC capabilities. I think that's a lost cause. But I think if you looked in the MA data, they have reasons for improving those sites of service. I mean, they do site-of-service enhancement payments now.

And I think the other reason that I would do that, you know, ASCs, it's a quick-moving front. You know, ASCs aren't just doing colonoscopies and cataracts now. I mean, again, they're doing these more intense procedures. And my concern is I think this really excellent criteria that you've used and the really excellent rationale that

you've used to adjust the payment is holding up right now while we're doing these simple procedures, using Medicare claims data that's going to suffer from this regression toward the mean phenomenon.

I think if you start looking at MA data and we try to advance this work and keep up with the ongoing increasing complexity of procedures that are done in ASCs, I'm not sure that this approach endures over time.

Having said that, I think you're off to a great start and I'm a huge supporter of the work, and I don't want perfect to be the enemy of the good here. So I do think you move forward. But I would do is periodically retest my hypothesis on the acuity adjustment, because again, I'm not sure that's going to hold up over time, as these ASCs escalate.

The final thing is what to do with the savings. You know, I think redistribution is a bad idea. I mean, I think Bruce put it well the other night when he said, "What's the point?" when we were talking about the redistribution solution.

And I think the stop-loss based on DSH eligibility is an excellent first start. I'm wondering,

too, and, you know, based on our previous conversations, maybe some of that $8 or $9 billion goes toward creating some incentives for ACOs too. I don't see why you couldn't use some of that for stop-loss insurance and redirect some of that toward APMs as well.

But with that, again, I am wildly supportive of the work and the methodology, and I think it's excellent. Thank you.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you very much for this fantastic analysis, and I think a bit ditto to a lot of the things that Brian set up front about how well rationalized everything was. I loved the approach. It really does highlight some places for what feels like relatively easy savings, although I know there's no such thing.

So, you know, I'm looking forward to hearing what the other Commissioners have to say. I would love to see this not be a budget-neutral adjustment, to be able to use these savings. Either keep the savings or use the savings for things like we were discussing yesterday, with some of the ways to incentivize addressing social determinants of health, improving safety nets. There are lots of other

important ways we can spent those funds.

But again, huge, huge kudos on a great analysis and a really well-laid-out chapter.

MS. KELLEY: Lynn.

MS. BARR: Thank you. I really, really enjoyed the chapter and your analysis of this, and I thought it was really a brilliant approach.

As we go into the last part of it, where you're looking at the options, understanding -- and I assume that the OPPS budget neutrality issue is an issue that we have to deal with, and that we can't take money out of the OPPS and give it to ACOs. It has to stay within the OPPS system, budget neutrality.

DR. ZABINSKI: By law, yes.

DR. MATHEWS: Yeah, you were on the right track. Absent any specific recommendation to do something otherwise, that money does remain within the OPPS. But the Commission could say take this dollar amount and use it for a different purpose.

MS. BARR: So they do have the flexibility to use it --

DR. MATHEWS: No. We have to recommend it.

MS. BARR: Oh, and then Congress has to pass a law.

DR. MATHEWS: That's correct.

MS. BARR: Okay. So given that, and the potential for --

DR. CHERNEW: If I understand what's being said, anything besides it being budget neutral with an OPPS needs some congressional action. You could do anything you want. You could send it to however you want to do it, but it would need some congressional action to do anything other than the status quo.

DR. DeBUSK: [Off microphone] redistribute exclusively the OPPS to the dollar amount, that was based on some value-based measure.

DR. CHERNEW: Not without a changing legislative thing you can't do anything besides what the legislation says, and what the legislation says is it's going to go into OPPS. And if you want to change anything, you need to change the legislation.

MS. BARR: I'm kind of sneaking a Round 1 into Round 2, and I realize that's not to be done here, and I do apologize.

DR. CASALINO: It's better than the other way.

MS. BARR: It's like I don't want to get in the queue twice, so I apologize for doing a little -- it is Round 2 but I got Round 1 in here. I'm sorry.

But my point is that barring an act of Congress this does give us an opportunity to potential right the ship with safety-net providers, and your recommendation of, well, you know, was for not a budget-neutral recommendation with your stop-loss. Stop-loss was not budget neutral, right?

And my question is, could you also suggest a scenario where those payments are redistributed under the OPPS to the safety net using your same -- so I think you're one chart short of a deck. I mean, I know we would rather save the money than not, but we also have the issue of margin in our safety-net providers, and our safety-net providers typically have more than 50 percent of their payments are outpatient, right, so they have a higher ratio. So the redistribution of those towards safety-net providers might actually solve some of our solvency issues in that area. I would request that you actually take another pass at that using budget neutrality and

redistributing it to what I would see as rural and governmental entities and folks over the DSH average or those that qualify for 340B, which goes even higher than above the median.

Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thank you. I also wanted to express great support for this work and thank you for driving it forward. I think we should, in general, have a relatively high degree of outrage that there's so much cost sharing impact based on site of service, meaning they're getting the exact same care and they're paying more for it, which seems just totally unfair.

I also think that the points around consolidation are very well stated, and I agree with emphasizing those are part of motivation for this work.

I substantively have a few different comments. One point is I think it is important to recognize -- and I think ASCs are certainly the category that applies most here, is that there is regional variation. So there are some markets in which you have a lot more ASCs, and there are other markets in which you have very few ASCs.

And so if we are trying to empirically define which procedures are more ASC than not and therefore could be switched, I think we are obligated to look at the regional level to see how that might vary, because, in fact, there may be a slightly broader set of procedures that could be shifted appropriately, which in this overall average analysis would end up kind of getting smoothed out. So I think that would be a helpful analysis to do.

In general, I will say while saving money for the program obviously is good thing to the extent, based on this last conversation, about the legislative need to do anything against budget neutrality, it seems like we could at least align the incentives to some extent, and this issue around cost sharing differences by site, in a budget-neutral world, and I think that would be a step forward, even if we can't get all the way to let's get the savings back to the program.

The safety net piece, I have to say I feel tension about. On one hand, to the extent that anything may take money away from the safety net obviously doesn't feel good. At the same time, I also feel like it's perhaps not the right thing to use different types of policies that

don't intrinsically have anything to do with the safety net as a way to try to support the safety net. And that has happened across the Medicare program in several different ways, and I think it creates a hodge-podge approach, which is inherently, in the long run, quite irrational or not coordinated in some fashion.

So I feel like there's a tension there, and if at all we could take those savings and then finance support for safety net truly through the safety net portion of the program, independent of OPPS, I think that would be a more appropriate way, I think, in the long run, to try to do this.

But, in sum, I'm very supportive of the work. Thank you for driving it forward.

MS. KELLEY: Lynn, did you have a question on that?

MS. BARR: A Round 1 question. Dan, so in the physician fees, when a hospital's bill for outpatient services, the co-payment is adjusted to the physician fee schedule, and so there's an adjustment so that people don't pay higher co-pays in hospital settings than in ambulatory settings. Isn't that correct?

DR. ZABINSKI: Well, that's the purpose of the analysis, yes.

MS. BARR: But, I mean, isn't the cost sharing automatically adjusted to the non-hospital rate? There was a law in 1995, that eliminated -- because rural hospitals pay 50 percent average cost sharing because that law does not apply to them. For critical access hospitals, for OPPS, it doesn't. So I'm confused about the higher cost sharing rate.

DR. ZABINSKI: No, there is a higher cost sharing under the OPPS and the physician fee schedule for the same service.

MS. BARR: Okay. I must be mistaken. Thank you.

MS. KELLEY: Jon Perlin.

DR. PERLIN: Let me join the chorus of appreciation for a very thoughtful analysis. It just proves how extraordinarily complex, but also to Amol's point, how interdependent the different pieces of the Medicare program are.

You know, first let me just simply identify with the concerns about differential cost sharing for roughly the same services.

Second, let me make explicit, or let me just sort of play back a little of what I heard. So there's explicit hypothesis that there's revenue maximization by virtue of choosing HOPD over other sites of care. Okay. Let's stipulate to that. But there's also part of your fact base, Dan, that there is no additional cost associated with the higher Charlson comorbidity index. Higher acuity patients didn't cost more.

I still think that leads to then what is implicit in this analysis is that there is no clinical judgment as to why some patient would go to Site A versus Site B, and I'm not sure that's true.

The reason I say that is that hospitals are clean-up centers for things in doctors' offices, in ASCs, that go bad. All of the people who are doctors, nurses, health system folks are nodding their heads. So I just note that, that there may be something else at play.

Now it doesn't mean that it would necessarily change the analysis here, but I just don't want to be dismissive of the fact that there may be elements of judgment about why a particular patient is called over, even if they don't end up costing more. Maybe by virtue of

a more protected environment that they didn't cost more, in fact.

Okay. So the next thing I just want to address is that it may be inherently rational to align the payment across the ambulatory setting, et cetera. But Bruce elicited in his Round 1 question two points, one, that your Slide 15 showed the sort of whole effect on total revenue for outpatients. Specifically it was roughly 3x. And I'm not disputing anything that was said. I'm simply making a point that, don't forget, all these decisions interact in extraordinarily complex ways. So they're going to interact with the OPPS update. They're going to interact with the IPPS update. They're going to interact with the end of the moratorium on the sequester. They're going to interact with the required payback of the accelerated payments under the CARES Act. So I just note that all those features come together.

And while my colleague, Mr. Pyenson, has demonstrated, with empirical data, that hospitals can react and stop on a dime, you know, you can stop a car on a dime if you run into a brick wall. You can also stop it if you brake carefully. I just would ask that we think about the

interactions of the different pieces of our policy.

And this is fundamentally my last point, why I agree with Amol's point about the safety net, is that inherently I am actually passionate about wanting to support the safety net, but I want us to be dispassionate about the thoughtful ways in which we use policy that's connected to its intent as opposed to derivative, because it only makes these tremendous interactions of the different pieces of our payment mechanisms ever more complex. Thanks.

DR. ZABINSKI: Can I make a point? There's a real subtle thing on the patient acuity that I think it's important to understand. In the outpatient PPS it's a pretty granular system, and we are finding that, on average, that the patients in the HOPD are sicker, not hugely so but they're sicker, on average, than patients in the physician offices. And it can be the case that the sicker patients in the HOPD might be more costly, but the point is that the hospital can bill under the OPPS for additional things that you might provide to a sicker patient, and get a separate payment for it on top of standard. It's a subtle point but it's there.

That's in contrast with the inpatient PPS, where they're a very set payment, and it doesn't matter what the patient's severity is. So it's a subtle point to understand.

DR. DeBUSK: On that specific point, I do completely agree that APCs are tiered and they can additively bundle APCs.

You know, I would think of, if you had a patient who was in for a particular musculoskeletal procedure and they happened to have, you know, some other severe, chronic disease, the challenge there is you would actually have to find something to do to them to be able to harvest that extra APC, because, for example, the musculoskeletal level is set by virtue of what they need fixed, I believe, not by virtue of how sick they are.

Is that a fair statement?

DR. ZABINSKI: I'm not sure. I would have to think about that.

DR. DeBUSK: Well, you know, say five levels of musculoskeletal procedures. Okay. Thanks.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Yeah, thanks. Dan, this is a

very valuable chapter and I'm glad you're doing it. To me the big takeaway from it, or one of them, is that to the degree that we reduce the rates in certain settings, like a hospital outpatient department, you know, following site neutrality, there are a lot of options of what can be done with the savings. And they could just go right to the program savings, which would, of course, benefit the beneficiaries as well, because their cost sharing would go down, or they could go to other things. And I want to make sure that we don't lose sight of the real reason we're advocating site neutrality, which is we want to steer patients to the site that can treat them most efficiently and with good quality. Also, the current rules are a very strong incentive towards hospital employment of physicians. That may not be the best way to organize our delivery system. And also, as the chapter mentions, it clearly contributes to consolidation as far as other physicians employed by the hospital, not referring to freestanding facilities for things.

So, in a sense, these are the reasons we are doing this, and I think it's very useful to point out to Congress that, well, you might want to legislate. There is

a current law solution, which is just to reduce the payment rates, but there are other possibilities. But I'm concerned that we get too wrapped up in talking about whether it should go to the safety net, whether it should go to the other OPPD services, which may be underpaid. I think it really reduces the potential impacts of this very, very important idea, something we've been at for a long time.

So it's not telling us exactly how to navigate this, but I don't want to lose sight of the motivation for doing this.

MS. KELLEY: Bruce.

MR. PYENSON: I think this work is actually among the most exciting and important that we've done. And when you think of the scale of the money at stake here, we're talking about money on the order of, you know, reversing the annual update of hospital payments. So this is a potentially big deal. I'm sure the other Commissioners won't be surprised to say that we should use all of it as savings.

There are other issues, safety net hospitals and the status of hospitals in general. You know, the sequence

of arguments against savings is, oh, well, the profits from these are used to offset losses elsewhere, or oh, if you make these cuts hospitals are going to stop doing these procedures. I mean, there's going to be a sequence of counter-arguments to that, but I think those have to be evaluated on their merits and adjustment made. Specifically, we've got other lines of work on safety net hospitals.

So I think this work really gets at the heart of some of the destructive incentives that the Medicare fee-for-service system has had in place for a number of years. And I have a sense that if we had started at a different reference point, we would have been even more aggressive in our findings, that is if we look back at before the shift to hospital outpatient had occurred and saw the distribution of where things were occurring, in particular physician office, we might come to different conclusions, or even more aggressive findings.

So I think actually is really exciting work and I want to compliment Dan and his team on this. Thank you.

MS. KELLEY: Pat.

MS. WANG: Thank you. The work is really

excellent, and I think that the comments that have been made are irrefutable when looking at the issue from a kind of a macro level, and the principles on Slide 16, you know, the principle that Medicare beneficiaries should not pay more than necessary, steering people to efficient sites of service, reducing incentives to consolidate are all great.

I just want to mention a couple of other things, though, because I have a little bit of a concern.

The issue around the increased cost sharing associated with the higher payment level for this suite of services is really important. The reason I was asking the question before about the sort of proportion of hospital-based, these services, by duals was to try to get at the point of who is actually paying that cost sharing. That is an estimate of what the cost sharing would be under Part B, but is it actually getting paid?

Because my hypothesis is that in many instances, where Medicaid is secondary, it is not being paid because of the federal laws, under the Deficit Reduction Act, that allow Medicaid programs to cap their payment, any cost sharing, at the level that the Medicaid program would have paid, standing in Medicaid's shoes. So if Medicare's rate

is $100 but Medicaid wouldn't have paid more than $80 for the service, Medicaid is not paying any co-insurance for that service. And so that's why I was sort of poking at that $1.4, $1.5 billion in sort of additional cost sharing associated with hospital-based services. It's just a question of whether that number is really falling on the shoulders of individual beneficiaries.

It's hard to argue with the principles on Slide 16, but I want to suggest a third principle that changes like this do not inadvertently increase incentives for hospitals to stop providing primary care and other services for which access is already constrained for many populations.

Now we are articulating that as sort of trying to protect safety-net hospitals, and I think it would be more important to think about it from the perspective of protecting the beneficiaries who may use safety-net hospitals. You know, you can take the money and create a separate stream of money to a safety-net hospital, but if they're still getting paid what they view as below their costs, let's say, to provide clinic services, they're going to stop providing clinic services. The things that drive,

in my view, how any provider structures its suite of products is what they're actually getting paid for delivering that service, not a general subsidy that comes through the back door, because that might go to enhance their trauma center, for example, which is also needed.

And this is my limited experience that hospital-based clinic services are used quite a lot by populations and in regions where there really is no alternative service. It's great to say we want to drive them to more efficient sites of care. We want to drive them to freestanding ambulatory care services and private physician offices. There are not those things in a lot of communities that rely on hospital-based clinic care. So I think we need to be careful about making those assumptions.

I'm really worried. I don't know what the solution is, but I'm worried, and I think that we should build in some factor of what will this do to access, to lower-income populations that rely on hospital clinics, as well as am-surg centers for care. Thank you.

MS. KELLEY: Dana.

DR. SAFRAN: Thanks. Just really brief, adding my compliments on this really important work and my

enthusiasm for it. I don't think this has happened before, where my comments were almost identical to the ones Bruce was going to make, but Bruce, maybe that gives you some comfort as you exit that I can channel you, at least partially.

MR. PYENSON: [Off microphone.]

[Laughter.]

DR. SAFRAN: So my reaction was 2 percent of Medicare spending saved through this one possible initiative, and even, you know, just doing it with a partial set of ambulatory conditions is just stunning, exciting. I too felt, let's take this as program savings, not as an opportunity for redistribution.

And my only comment, which probably won't surprise others, is I think to drive home the power of the differential payments, you know, the visual that shows the dollar amounts I pointed to in my question, I think, is incredibly powerful, the fact that the close to $600 in the OPPS amount is 10 times more than the work amount that physicians are paid in the practice setting.

So I just think that's incredibly powerful, and that having a visual that shows what we can about the

quality comparison for the two settings would help drive the point home. If we have no quality measures that we can put forward to do that with for the services that we're choosing, then I'd be glad to work with you on some other ideas for how we could capture that. But I think that helps drive home just the completely unacceptable, unexplainable differences in payment for services where really, we can't make the case that there's added value being provided. Thanks.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. Really excellent work, Dan, and excellent comments from the Commissioners too.

I just have a couple of very simple things to say. One is I think that there have been a lot of good kind of qualifications made and probing of different complexities in this, but I would hate to see those get in the way of the overall message, which is where does that $583 come from in the example. That is a lot of money, and it seems to me, as other Commissioners have said, that this is something that really something should be done about, and sooner rather than later.

Mike's comments about the last time he was on the

Commission they were working on aligning payments and not that much has happened since is worrisome. So I don't want us to contribute to the prolonging of what's kind of being irrational, I think, by adding in too many complications.

In fact, I don't know what the mechanism is for this would be, but beyond actually having a chapter I would love to see, at some point, if we could move toward a recommendation.

The only other thing I have to say is about the risk adjustment. I think Bruce's and Jonathan's points are well taken about this, by the type of procedure and by the type of patient. So I can easily believe that for cataract surgery the number of chronic illnesses to patient has may not matter very much, if at all. But that may not be the case with a hip replacement or a knee replacement, and with some other more complicated procedures.

And also clinical risk and socioeconomic risk are highly correlated but they aren't actually the same. And even for cataract surgery, what the patient does after the surgery is actually kind of important for the first week, and especially the first couple of days after the surgery. You may get patients with different degree of SDOH

disadvantage may get different outcomes, actually, even for a relatively simple surgery like that.

So I do think that, again, I would really hate to see this hold up -- well, it's not going to hold up the chapter, and I hope it won't weaken the chapter, or if we do ever more toward a recommendation, I wouldn't want to see any of this get in the way of that. But I think that probably, as Bruce said, there should be ongoing consideration of both by the type of patient and the type of procedure some kind of clinical and/or SDOH risk adjustment or stratification important.

And then the only other thing I would say about this, I do think that patients are different in ways that neither of those things may capture, and when physicians choose to send the patient to a hospital HOPD instead of an ASC, there may be reasons for that that are actually good reasons, and they're not just that the patient doesn't have insurance that pays well. That certainly is a reason that physicians refer to the HOPD rather than doing it themselves at an ASC. But there probably are cases in which it's more appropriate for the patient to be at an HOPD, even though we don't see them and can't get it from

claims data.

Again, I wouldn't want to let this get in the way, and I don't think there's $583 worth of reasons why, but I would be okay with some kind of small added payment to hospitals for the kind of considerations that Jonathan was bringing up. And I would want it to be small. I wouldn't want it to be big enough that it fosters further consolidation, for example, of hospitals buying physician practices. But I don't think it necessarily should be off the table, but it shouldn't be $583. It probably shouldn't even be $58, but you want to consider something.

Again, though, really, this is such a bad policy right now, I wouldn't want to let any of these considerations get in the way of some movement toward action being taken sooner rather than later. It really is a lot of money at stake, and it really is driving consolidation that may not be healthy.

DR. CHERNEW: I think that was the last comment, and so that's good because we're going to, in a moment, say goodbye to a bunch of folks and take some pictures.

I want to say one last thing on this point before we move on, and that is one thing that I thought you were

going to emphasize, and while you mentioned consolidation several times, Larry, and I knew you would, is understand that a lot of what has actually already given rise to this problem has been the consolidation. So a lot of what is happening is the actual past consolidation is taking the same exact entity and just changing the payment in this arbitrage sort of way. And so it's not just going forward. Some of the problem is a reflect. Now not all of the problem is that reflection.

So the points which I think were clear is we do have to think about the considerations, for example, for access. We have to figure out how to make sure that we aren't held up by concern about organizations that might be adversely affected, but we are cognizant of those adverse effects and find ways to think through them. That is just a challenge for what we're going to do.

So the nice thing about this chapter is we are going to be continuing this work as we go next cycle and get to recommendations, so there will be more time to go through that. The problem with that is we actually -- and I say this for the folks at home -- we are losing some stunning good Commissioners, and I just want to say, in

public, an acknowledgment and a thanks to them for what they have done. So my Vice Chair Paul, Brian, Pat, Bruce, and Jon Perlin. It is amazing the contributions you have made to the Commission, to the program, and of course in your other lives, and I just want to say broadly thank you very much. This is our last meeting for the cycle, and we will really, really, really miss your contributions. So again, thank you.

To those of you at home, you can comment on any of the sections today or just send congrats to the departing Commissioners, or commiserate with us about their leaving, but you can send those comments to MeetingComments@medpac.gov, or go to the Public Meeting section of the MedPAC website, under Past Meetings, and send comments there. We really do want to hear from the public their thoughts on these things.

And with that I want to thank all of the Commissioners for a wonderful day. I want to thank the staff for exception work. Dan, this was great, and I don't see Luis, Rachel, and Geoff here. Oh, there's Luis. There you go. Luis, take back to your colleagues what a great job you all did today. And to everyone who presented

yesterday on Part B, Part D, and SDOH, you guys did a great job.

I think we've had a great cycle and look forward to everybody getting to see how this plays out in the June report, for those chapters that make it there.

So again, thank you all, and if I can ask the Commissioners to stay for just for a moment so there can be a picture taken, that would be great. And to everyone else, thanks for joining us.

[Whereupon, at 11:50 a.m., the Commission was adjourned.]